S. HRG. 101-1266

# PROFILES IN AGING AMERICA: MEETING THE HEALTH CARE NEEDS OF THE NATION'S BLACK ELDERLY

## JOINT HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING

AND THE

## CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST

## UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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FRIDAY, SEPTEMBER 28, 1990

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# PROFILES IN AGING AMERICA: MEETING THE HEALTH CARE NEEDS OF THE NATION'S BLACK ELDERLY

FRIDAY, SEPTEMBER 28, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST,
*Washington, DC.*

The committee met, pursuant to notice, at 9:38 a.m., in room 216, Hart Senate Office Building, Hon. David Pryor (chairman of the committee) presiding.

Present from the Special Committee on Aging: Senators Pryor, Glenn, Shelby, Reid, Kohl, Heinz, and Grassley. Present from the Congressional Black Caucus Health Braintrust: Representative Stokes.

## OPENING STATEMENT BY SENATOR DAVID PRYOR

The CHAIRMAN. Good morning, ladies and gentlemen. We are proud to have all of you here this morning.

This is an historic joint hearing of the Senate Special Committee on Aging and the Congressional Black Caucus Health Braintrust. Our meeting will now come to order.

At this time, I would like to allow my distinguished colleague from the House of Representatives, who I had the privilege of serving with some years ago in the House of Representatives, to make his opening statement. May I present to the Committee this morning the Hon. Louis Stokes from the State of Ohio.

Congressman Stokes.

## STATEMENT OF CONGRESSMAN LOUIS STOKES

Mr. STOKES. Thank you very much, Senator Pryor and members of the Senate Committee on Aging, and ladies and gentlemen.

First, let me say what an honor and privilege I deem it to have the opportunity this morning of convening these joint hearings under the leadership of Senator Pryor, who as he just said, served with me when he was in the House as part of the long and distinguished career that he has had. It is also indeed an honor to be here this morning with my own Senator, Senator John Glenn of the State of Ohio, with whom I am also proud to serve; also Senator Kohl and Senator Grassley, whom I also served with when he was in the House.

This is the first time that the Health Braintrust has convened a joint session with the Senate Committee on Aging. Let me say from

the outset that I want to thank Chairman David Pryor for taking the leadership and also for the role that he has played in addressing the needs of our elderly. Because of his commitment and concern, we are able to join together in this historic setting.

During my tenure in Congress, and in particular, through my work as a member of the Labor, Health, Human Services and Education Appropriations Subcommittee, I promoted on behalf of the Congressional Black Caucus, our mutual concerns regarding the health care status of black and minority Americans. With the input and support of the Health Braintrust members, we have been able to achieve many accomplishments in this regard.

Mr. Chairman, I want to take a moment to tell you and the other members of the Committee just how hard this group has worked to improve the health status of minority Americans. One year ago almost to the day, our distinguished colleague here in the Senate, Senator Ted Kennedy, and I introduced the Disadvantaged Minority Health Improvement Act. With the assistance of the Braintrust members, I am proud to inform you that this bill, on Wednesday, passed the full committee in the House and is now scheduled for Floor work in the House next week. Having passed the Senate last fall, this bill is fast approaching enactment into law.

This significant effort could not have happened without the Congressional Black Caucus Health Braintrust. I say all this to let you know, Mr. Chairman, that you have before you a group here this morning that is willing and able to tackle the enormous issue before us today; that issue being meeting the health care needs of our Nation's black elderly.

In preparing for today's hearing, I was reminded of a quote of the late President John F. Kennedy in a special message to the Congress on the needs of the Nation's senior citizens. He said:

> The increase in the lifespan and in the number of our senior citizens presents this Nation with increased opportunities: the opportunity to draw upon their skill and sagacity, and the opportunity to provide the respect and recognition they have earned. It is not enough for a great Nation merely to have added years to life. Our objective must also be to add new life to those years.

Over the course of this morning, experts from all disciplines will discuss the health challenges confronting our black aging. We will hear how, in recent years, these challenges have multiplied; how the well being of our elderly has been jeopardized and what unique characteristics they have. What stands out to me most, however, is that of all the issues on which I have received postcards, mailgrams, petitions, letters, not to mention phone calls, nothing has surpassed the expressions of concern about health and long-term care. There has been an outpouring from the elderly on this issue. From what we are being told here in Washington, health and long-term care tops the list of our elderly's concerns.

Mr. Pryor and I have spent the last year-and-a-half on the Pepper Commission. He and I can both attest that we deliberated the full scope of health issues confronting our Nation. Through a series of national public hearings similar to this today, the Commission examined the complex and controversial questions associated with inadequate health and long-term care. Many of you here participated in the process. Rest assured that what you told us has not gone unheard. In fact, because of the work we undertook, Mr.

Pryor and I left those deliberations more determined than ever to come up with solutions to the problems our elderly and all Americans are encountering.

That is what brings us here to this historic event this morning. The Congressional Black Caucus Health Braintrust and the Senate Special Committee on Aging are determined to make a meaningful effort to better the quality of life for our black elderly. I am confident that working together collectively with everyone assembled here today, we can provide the commitment, the leadership, and the support necessary to meet the health challenges confronting our elderly. Our black seniors, the heart and soul of the black community, the strength and courage of our community through the years, deserve this.

I thank you, Mr. Chairman, for recognizing me and I yield back to you at this time.

[The prepared statement of Congressman Louis Stokes follows:]

News *from*
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FOR IMMEDIATE RELEASE
SEPTEMBER 19, 1990

CONTACT: LESLIE ATKINSON
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**CONGRESSMAN STOKES CONVENES HEALTH BRAINTRUST IN CONJUNCTION WITH CBC 20TH ANNUAL LEGISLATIVE WEEKEND**

**Washington, D.C.** Congressman Louis Stokes (D-OH) Chairman of the Congressional Black Caucus (CBC) Health Braintrust, announced that he will convene the annual Health Braintrust on Friday, September 28, 1990. The meeting is being held in conjunction with the Congressional Black Caucus Foundation 20th Annual Legislative Weekend in Washington, D.C.

As a leader on health policy for minority Americans, Representative Stokes will host a day-long program focusing on the health of Black elderly, as well as on the future direction of health care for minorities. Congressman Stokes is the author of the landmark Minority Health Bill of 1990 which was recently passed by the Senate. The measure was also marked up in House Subcommittee and will soon be considered by the full Committee and on the House Floor.

The September 28th meeting will begin at 9:30 a.m. in Room 216 of the Hart Senate Office Building with a Joint Hearing of the CBC Health Braintrust and the Senate Special Committee on Aging, chaired by Senator David Pryor (D-AR). The hearing entitled, **"Meeting the Health Care Needs of Our Nation's Black Elderly"**, will focus on the current health status of these elderly Americans. Witnesses scheduled to testify include: Dr. Joyce Berry, U.S. Commissioner on Aging; Presidents of major national minority health professional organizations; and key public service and advocacy groups for the Black elderly, including the National Caucus and Center on Black Aged.

The afternoon session will convene at 2:00 p.m., and is entitled **"Visions of the Future: The Year 2000 Health Objectives and Minority Americans."** Health and Human Services Secretary Dr. Louis Sullivan will lead the discussion on the objectives; how they address the unique health care concerns of Black and minority Americans, and how the health objectives will be implemented in minority communities.

Congressman Stokes, reflecting back on the twenty years of accomplishments of the Congressional Black Caucus commented, "There is no issue of greater importance to our nation in terms of domestic policy than that of health. In terms of examining our health record as it relates to the Black elderly, and future challenges in minority health, this year's Braintrust is particularly significant. As we debate national health care reform, the CBC Health Braintrust agenda will lay the foundation for legislative initiatives and policy in the upcoming decade."

For further information, contact Leslie Atkinson at 225-7032. A detailed map of Capitol Hill, including the location of the Hart Senate Office Building can be found on the reverse.

News *from*

# CONGRESSMAN LOUIS STOKES

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FOR IMMEDIATE RELEASE
SEPTEMBER 13, 1990

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**CONGRESSMAN STOKES LEADS EFFORT AS MINORITY HEALTH LEGISLATION CLEARS HURDLE ON CAPITOL HILL**

**Washington, D.C.** Congressman Louis Stokes (D-OH), Chairman of the Congressional Black Caucus Health Braintrust, announced that the House Energy and Commerce Subcommittee on Health and the Environment today took the first step in enacting the most significant minority health legislation ever. The Subcommittee successfully marked up legislation aimed at improving the health care status of minority Americans. Stokes is credited with creating the framework from which the Subcommittee crafted the measure.

"Today we took an important first step," said Stokes, a twenty-two year veteran of the House. "We have successfully begun a concerted effort to raise the level of national commitment to improved health care for our minority population. This legislation is evidence of the conviction of myself and my colleagues in the Congress to meet the challenge."

Specifically, this legislation is targeted at lessening the growing health gap between minorities and non-minorities in the United States. Through a combination of increased funding for health promotion and disease prevention activities, and initiatives focused on increasing the supply of minority health professionals, it is hoped that the crisis in health experienced by minorities can be lessened. The measure enjoys the broad-based support of many organizations who have worked closely with Congressman Stokes on health initiatives, as well as Members of Congress and the Secretary of Health and Human Services, all of whom share his concern. The bill will now be sent to the full for consideration before reaching the House Floor. A companion measure was adopted earlier in the Senate.

Congressman Stokes said the Subcommittee action was very timely. "In just a few weeks," he said, "I will convene our annual Congressional Black Caucus Health Braintrust. Many of the individuals involved in the Braintrust have worked tirelessly over the years to develop legislative initiatives in the area of minority health. It is a good feeling to be able to report that our hard work is finally paying off."

The CHAIRMAN. Congressman Stokes, thank you. You know, it is shocking in the year 1990, there still exists in our great country a racial health gap between blacks and whites. Many black older Americans today are suspicious of health care professionals and are intimidated by medical technology. In many instances, the lack of access to quality treatment in urban and rural communities is an enormous hindrance, a great burden, and serves to shape negative attitudes toward medical care. Further, a recent Department of Health and Human Services study reported that black elders themselves view their overall health status in the fair to poor range.

The familiar litany of health care concern assumes an even greater urgency in the context of the minority community. Congress today is continuing to grapple with the long-term health care dilemma and how best to provide insurance coverage to all Americans.

Earlier this week, the Pepper Commission released its final report. Congressman Stokes and I both served as members of the panel. It was chaired by the distinguished Senator from West Virginia, Senator Jay Rockefeller. We learned firsthand during this year of deliberations the difficulties in reaching any solution to these twin concerns, but today I think all of us are unanimous in finding it totally unacceptable to admit that thousands of Americans must choose between the very basic necessities of life and medical care, simply because they cannot afford both. Black elders face this choice in disproportionate numbers.

There are still so many questions for which there are no answers. One puzzling question surrounds the continuing disparity in life expectancy rates between blacks and whites. Why is the average life span of black males 65, when white males live 7 years longer? What factors contribute to the higher incidence of death from strokes in the black community? Blacks have the highest cancer mortality rate of any population group in our country. Is this totally unexplained phenomenon real, or is it fiction? Our purpose this morning is to shed some light on these and other issues with respect to the black elderly in the United States of America.

We are so indebted this morning to have shared in the work and profited from the research of the National Caucus and Center on Black Aged. They have assisted us in every step of the way in preparation for this meeting. Samuel Simmons, the Executive Director of that fine organization, has provided invaluable materials and resources. We thank Mr. Simmons for his wonderful efforts.

Once again, let me say a word about Louis Stokes. Throughout his long and distinguished career in the House, we have had the opportunity to share in many experiences trying to assist in bringing a higher quality of life, not only to blacks, but to all Americans. I am delighted, too, that this agenda item this morning is a part of the twentieth anniverary of the Congressional Black Caucus.

Louis Stokes, we congratulate you. We thank you.

[The prepared statement of Senator Pryor follows:]

DAVID PRYOR, ARKANSAS, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

STATEMENT OF SENATOR DAVID PRYOR
SEPTEMBER 28, 1990
"PROFILES IN AGING AMERICA: MEETING THE HEALTH CARE NEEDS OF THE NATION'S BLACK ELDERLY"

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Ladies and gentlemen, I am delighted to welcome you all to this very special and historic hearing. We have turned our attention to a discussion of the specific health care needs of the Black elderly. Very often, the special needs of minority groups are discounted or ignored. This hearing will begin to rectify this regrettable situation by calling on several panels of experts, caregivers, and health care professionals to discuss the health status of Black older Americans.

It is shocking that in 1990, looking toward the 21st century, a racial health gap exists between Blacks and Whites in our nation. Many Black older Americans remain suspicious of health care professionals and are intimidated by medical technology. In many instances the lack of access to quality treatment in urban and rural communities is an enormous hindrance, and serves to shape negative attitudes toward medical care. Further, a recent Department of Health and Human Services study reported that Black elders themselves view their overall health status in the "fair" to "poor" range.

The familiar litany of health care concerns assumes an even greater urgency in the context of the minority community. Congress continues to grapple with the long-term care dilemma, and how best to provide insurance coverage to all Americans. Earlier this week, the Pepper Commission (the Congressionally mandated panel convened to address the issues of access and long-term care) released its final report. Congressman Stokes

and I both served on that panel, and we learned first-hand the difficulties in reaching any resolution to these twin concerns. I find it unacceptable to admit that thousands of Americans must choose between the basic necessities of life and medical care, simply because they cannot afford both. Black elders face this choice in disproportionate numbers.

There are still so many more questions than answers in any discussion of the health status of the Black elderly. One puzzling question surrounds the continuing disparity in life expectancy rates between Blacks and Whites. Why is the average life span of Black males 65, when White males live seven years longer? What factors contribute to the higher incidence of death from strokes in the Black community? Blacks have the highest cancer mortality rates of any population group in the nation. Is this a totally inexplicable phenomenon? Our purpose this morning is to shed some light on these, and other troubling issues, with respect to the Black elderly.

My staff and I are indebted to the work of the National Caucus and Center on Black Aged. Samuel Simmons, the Executive Director of that organization, has provided invaluable materials and resources. My sincerest thanks to Mr. Simmons for all his efforts.

Before we begin, I must also say a special word about my esteemed colleague, Congressman Louis Stokes. Congressman Stokes has been in the forefront of minority health issues throughout his long and distinguished career in the House, and I am especially honored to share these proceedings with him today. I am also delighted that I can take part in celebrating the Twentieth Anniversary of the Congressional Black Caucus. My congratulations to Congressman Stokes, and each of the Members of the CBC for their unyielding efforts on behalf of the African American community.

We will begin this morning's hearing, with a special treat. We plan to preview a portion of a documentary that was produced by the Greater Washington Chapter of the Alzheimer's Association, in collaboration with Howard University. The film will air in its entirety on Channel 32 in mid-October. This documentary was the brainchild of a brilliant doctoral candidate at Howard, Mr. Michael Fain. Mr. Fain could not be with us this morning, but his Doctoral Dissertation Advisor, Dr. Joan Payne-Johnson is on hand to bring us a brief introduction before we present this five minute clip.

We have assembled a most distinguished group of experts to help us sort through the topic at hand, and I look forward to their testimony.

DAVID PRYOR, ARKANSAS, CHAIRMAN
JOHN GLENN, OHIO
BILL BRADLEY, NEW JERSEY
QUENTIN N. BURDICK, NORTH DAKOTA
J. BENNETT JOHNSTON, LOUISIANA
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

September 28, 1990

Dear Friends:

I am delighted that you have joined us today for this historic joint session of the Senate Special Committee on Aging, and the Congressional Black Caucus Health Braintrust. As we focus on the specific health care needs of the African-American elderly, I look forward to hearing the recommendations from our distinguished panel of experts, caregivers, and health care professionals.

As you may be aware, the Special Committee on Aging enjoys a broad mandate to explore and investigate any aspect of life as it impacts on older Americans. In keeping with this mission, it is fitting that the Committee would undertake a comprehensive examination of the special concerns of the Black elderly. The specific health care needs of minority groups are often overlooked, or discounted. Today's hearing is one step toward rectifying this regrettable attitude.

I am honored to share the podium with my esteemed colleague from the House of Representatives, the Honorable Louis Stokes. Congressman Stokes has been a leader in the field of minority health issues for many years. As we celebrate the twentieth anniversary of the Congressional Black Caucus, I am delighted to join forces with Congressman Stokes on this important topic.

It is also my hope that you will feel free to call on us at the Senate Aging Committee if we can provide additional information on the subjects discussed this morning, or any other age-related item.

Thank you for sharing this historic event.

Sincerely,

David Pryor
Chairman

The CHAIRMAN. We will move into the hearing in just a moment with a 5 minute film clip that I will talk about in just a few seconds. First, let me yield—I think I will use the early bird rule—let me now yield to Senator John Glenn of Ohio.

Senator Glenn.

## STATEMENT OF SENATOR JOHN GLENN

Senator GLENN. Thank you, Mr. Chairman. I have just a few remarks here. I want to commend you for holding today's hearing about the particular health care needs of elderly black Americans. I am extremely pleased that the hearing is being held in conjunction with the Congressional Black Caucus Health Braintrust, chaired by our good friend Congressman Lou Stokes, who is the senior member of our Ohio delegation. He has been here longer than any of the rest of us and we turn to him for counsel, wisdom, and judgment on all of these matters and work with him on that.

It is always a pleasure to work with Lou and the Ohio delegation, and quite often when we work together, it is on health issues. Congressman Stokes is truly a leader in this area and his work on minority health issues both in Congress and with the Health Braintrust will be invaluable to this Committee as we attempt to improve the quality of life for our Nation's black elderly.

Many of the issues we will be discussing today are issues of importance to all Americans—how to provide and pay for a wide range of health services including home and community based care; how to protect the elderly from the burden of out-of-pocket costs for prescription drugs and preventive care and other medical expenses not covered by Medicare; the need for increased funding for biomedical research and for research and training in geriatrics and gerontology; and the importance of health promotion measures for people of all ages.

In some ways I am reluctant to single out particular health care concerns of the black elderly. As we all know, many older Americans have health care problems. Also, just as with the entire older population, the older black population is a heterogenous group. But on the other hand, information is available which very clearly points out the need for special attention regarding health care for our older black population. David just referred to some of that a moment ago.

It will be helpful to hear from today's witnesses about the shorter life expectancy of black Americans; their higher incidence of many chronic diseases; the lack of adequate health insurance and care due to their lower economic status; and about the changes which we must make in the delivery of health care and in the training of health professionals in order to improve the health status of older black persons.

I thank all of today's witnesses for your participation in this hearing. As advocates for black Americans and for the elderly, the information you provide will be very helpful as we try to work together to ensure consideration of the particular concerns of our Nation's black elderly during Congressional debate on health care issues, which really are enormous and are before us now.

Chairman Pryor and Congressman Stokes, I thank you for your leadership in holding this hearing. I believe that today's testimony will be very helpful in sensitizing us to the particular concerns of elderly black Americans and will be very important as we work to meet the challenges presented by our growing elderly population.

As happens on Capitol Hill, I have another hearing I am supposed to be at in about 6 minutes. I am going to have to leave to go to that, but a staff member of mine who is with me, Diane Lifsey, will be here today. I will try to get back later on for the hearing, but if you have areas of particular concern that we can help out on, contact Diane. I will try to be back a little later in the hearing.

Thank you, David.

The CHAIRMAN. Thank you, Senator Glenn.

Senator Kohl of Wisconsin is next.

## STATEMENT OF SENATOR HERBERT KOHL

Senator KOHL. Thank you, Senator Pryor, Congressman Stokes, and the Congressional Black Caucus Health Braintrust for calling this hearing. I believe that everyone here today would agree that the special health care needs of elderly black Americans have been largely ignored in the past. I hope that today's hearing will help to focus attention on this important issue, and I particularly hope that it will lead to some meaningful solutions.

In preparing for this hearing, I was disturbed by many of the statistics on the health care status of the black elderly in my own State of Wisconsin. Nearly 60 percent of black Wisconsinites between the ages of 18 and 64 have no private health insurance. This leaves most without access to basic preventive and primary health care services in early adulthood and in middle age. This results in drastically lower life expectancies and more serious problems for those who live long enough to receive Medicare.

I am also troubled by low black enrollment in medical schools. In my own State, not a single black student enrolled in the Medical College of Wisconsin in 1988. According to the president of the medical college, the entire State of Wisconsin fielded just one black native Wisconsinite as a medical student nationwide; just one that applied to medical schools across the entire country, just one. And in Milwaukee County where the majority of Wisconsin's black senior citizens live, fewer than 15 percent of eligible low-income blacks were served by nutrition programs under the Older Americans Act in the first quarter of this year.

While these statistics are disturbing, so is the lack of data on the health of elderly blacks. I found that Wisconsin Division of Health bases nearly all of this data on morbidity tables. Although this information clearly helps to determine the leading causes of death, it hardly paints the full picture. Complete, accurate data on the health of black Americans of all ages must be collected in order to address the needs of this population.

I look forward to hearing from our distinguished witnesses today. I will be particularly interested in their thoughts on access to preventive health care services, outreach efforts, and practical solutions to some very difficult problems.

Again, I thank the chairman and the Black Caucus for their leadership on this important issue. I am very pleased to be here with you this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kohl, we thank you.

Senator Grassley from Iowa.

## STATEMENT OF SENATOR CHARLES GRASSLEY

Senator GRASSLEY. Thank you, Mr. Chairman, and thank you for holding this meeting; also to the Congressional Black Caucus Health Braintrust for their leadership in this area. If Congressman Stokes had not mentioned working with me while I was in the U.S. House of Representatives, I would still have said that I have nothing but fond memories of the 6 years working with Congressman Stokes. He has been very much a gentleman and a person that I could work with even though we are from opposite political parties.

I also think that the term braintrust speaks a lot about what this meeting is all about, because as Senator Pryor said: We don't have answers—we are looking for answers. If there is one thing that Congress needs, it would be to divide that one word into two words. We need lots of brain and, more importantly, we need lots of trust if we are going to solve these problems.

Judging from our witness list, this should be a very productive meeting. I understand also that the group plans to have a series of hearings in the next Congress on the minority elderly, and I believe that it is a very good idea to do so. The Committee can do a service by bringing into focus the concerns of our ethnic elderly communities and by helping to make sure that they are getting a fair shake from our Federal programs.

From the Republican side of the aisle, I thought that by coming to this meeting I would have a chance to welcome Joyce Berry. It is my understanding that she is not able to be here today because she is sick. I am sorry that she cannot be here. If she were here, even though she was confirmed some time ago, I would like to personally congratulate her and tell her how pleased I am to see her as Commissioner, even though it took a long time to get that job done.

Dr. Berry was strongly supported by all of Iowa's area agency directors and by our State Director, Betty Grandquist. They were all pleased and relieved to see her confirmed and look forward to her leadership in this area.

I also would commend to our Committee as well as to the Congressional Black Caucus Health Braintrust the name of Mary Majors of Cedar Falls, IA, who at the time I suggested her name to Senator Dole, who in turn appointed her to the Federal Council on Aging, was the only black member of the Federal Council on Aging. She still serves, having been reappointed by Senator Dole to another term on that Council on Aging.

Mr. Chairman, I look forward to this hearing, and not only to this one, but as they continue into next year, to addressing a very major need that has been identified by our leadership here in the Congress.

The CHAIRMAN. Senator Grassley, thank you very much for your contribution.

Senator Shelby of Alabama.

## STATEMENT OF SENATOR RICHARD SHELBY

Senator SHELBY. Thank you, Mr. Chairman. It is a pleasure for me to be a part of this hearing today. I also want to take a moment to again welcome my friend and former colleague, Lou Stokes from Ohio, to this side of the U.S. Capitol.

I commend you, Mr. Chairman, for your effort, and I want to welcome this panel of witnesses who have distinguished themselves through their work in the field of health care. I am particularly pleased to have Congressman Stokes join with this because he has contributed so much to health care in the Congress of the United States. His work has been invaluable in shaping health care policy for all minority Americans.

Over the last 20 years, as most of us know, the gap in health care between African-Americans and whites has been narrowed. Infant mortality in the black community has declined by over 50 percent. The average difference between blacks and whites has decreased from 7.4 years to 5.8 years.

Mr. Chairman, while these statistics clearly show a lot of progress, disturbing disparities still exist in the general health of whites and racial and ethnic minority groups. The Department of Health and Human Services reports that African-Americans continue to have an infant mortality rate twice that of whites and a death rate 1.5 times higher.

In addressing the health gap between minorities and nonminorities in the United States, I believe, Mr. Chairman, that we must take into account the unfortunate fact that the socioeconomic status of minorities, especially in rural areas of America like my State of Alabama, disproportionately puts these individuals in a position, as you pointed out, Mr. Chairman, to choose between basic life necessities and medical health care. This is particularly frustrating in light of the fact that the causes and effects of such diseases as cancer, stroke, diabetes, and heart-related conditions, which together account for almost 80 percent of excess deaths among minorities, can be lessened with preventive medicine and access to quality health care and treatment.

Mr. Chairman, it is my sincere hope that the day is fast approaching when no elderly person will have to live with the threat of exclusion from our Nation's health care system. Hearings such as you have set up today give us an opportunity to come together and try to bring some understanding as to how we in Congress may increase and refine our efforts to address the specific health care needs of minorities. We need to bring some parity to the overall health care of all Americans, and this is a beginning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Shelby.

Now, even though Senator John Heinz has just arrived, and even though he is the Vice Chairman of the Special Committee on Aging, and notwithstanding the fact that tradition demands that I call on the ranking member from that side of the aisle at this time—we have already adopted the early bird rule, John—so I am

going to yield to Senator Reid from Nevada and then have you do the cleanup slot, if you would.

## STATEMENT OF SENATOR HARRY REID

Senator REID. We are all anxious to get to the movie.

Mr. Chairman, again, I express my appreciation to you and your staff for arranging this hearing. There are a number of reasons that I am happy to be here, not the least of which is to welcome my colleague, Congressman Louis Stokes. During the time that I served in the House, he stood out as one of the leaders of that very large body. Since coming over here, my appreciation for Congressman Stokes has only improved in watching the many good things in which he is involved.

Mr. Chairman, I would like to welcome all of the witnesses here as you have done. As we all know, advanced age does not equate to poor health for all seniors, but it does bring poor health for some. Coupled with the vast inequalities in the health care available to Americans, particularly minorities, old age can be a multiple burden.

I am pleased that we will today be investigating the health care access of America's black elderly. Behind the inequalities in health care for black Americans are differences in health care needs and access.

According to the "Journal of the American Medical Association," blacks are more likely to require health care, but less likely to receive health care services. This disparity in health care parallels that of education and income, serving to perpetuate the lack of access to resources. I think that we have to recognize that this lack of resources all too frequently impacts upon minorities.

Educational inequalities translate into income inequalities which in turn lead to health care inequalities. Black Americans are less likely than whites to receive organ transplants, undergo cardiac surgery, or even be hospitalized. They experience a greater incidence of high blood pressure, yet, are less likely to be treated for high blood pressure. While these inequalities are not unique to the senior population, they do set the stage for a future of health problems for a person who has had less than adequate health care all of his or her life.

We know, Mr. Chairman, that, through this great series that has been running on public television, we have learned a lot about the formation of our country. We were reminded frequently during that program of the ills of segregation. It was found to be unconstitutional many years ago. I think that the time is long past due that we should no longer segregate the ability of people to obtain medical care.

The CHAIRMAN. Thank you, Senator Reid.

We will now hear from our Vice Chairman, Senator Heinz.

## STATEMENT OF SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, do you mean that we didn't plan it this way?

The CHAIRMAN. We didn't plan it this way, but you got the best of all deals. [Laughter.]

Senator HEINZ. Mr. Chairman, first, I want to join you in welcoming the most distinguished audience that we have today. I also welcome Congressman Lou Stokes. You and I both had the privilege of serving with the Congressman for the better part of a year-and-a-half on the Pepper Commission. Thanks to his extraordinary sensitivity and advocacy, the Commission was able to focus in ways it never would have on the problems that minorities of all ages have in accessing our health care system.

I commend you, Mr. Chairman, on this hearing to focus on the health care needs of the Nation's black elderly. We have the idea in this country that eveyone is equal under the law. That remains a primary goal of this Congress and the American public. We have not achieved it yet, but we continue the fight. The Senate—and we hope, very quickly, the House—just reaffirmed the principle of equality in the workplace for all Americans, regardless of race, religion, gender, and specifically, age, with legislation designed to reverse the Supreme Court decision in the so-called *Betts* case. Senator Pryor was a very key participant in writing that legislation.

The same principal of equality of access should apply to health care, too. What the statistics tell us, however, is that principles and practice do not necessarily follow the same path. When we look at morbidity, it is painfully obvious how color-biased the numbers are.

Black elderly are 50 percent more likely to describe their own health as fair or poor. A black elderly person who lives to age 65 can expect over a full year less to live than a white person reaching age 65. Hypertension, cerebrovascular disease, diabetes, arthritis—these are some of the health conditions that affect our Nation's black elderly significantly more than the white elderly. These figures are testimony to the fact that we are not adequately meeting the health care needs of our Nation's black elderly.

The devastating effects of poverty, with the black elderly more than three times as likely to be in poverty than while elderly, certainly contribute, but the problem may lie even deeper. Just this last Tuesday, there was an article in the New York Times discussing the need for physicians to take into account the racial and ethnic backgrounds of their patients in diagnosing and treating them. We need to learn more about why these differences arise and to act on what we know.

Where there are barriers to care, we must lessen them. Where there is lack of health education in the community, we must teach. Where there are unique health problems, we must tailor health care services. The goal of equal access to high quality care for all Americans is a paramount goal, but we must recognize that this must be achieved in varying ways.

Mr. Chairman, I want to ask a special favor of the Committee. I would like to extend a special welcome to one of our witnesses here today, a fellow Pennsylvanian whom I have known for longer than he or I would care to admit, Gorham Black.

If I might have the indulgence of the Committee, I would like to take the opportunity to present to Gorham Black a special certificate of appreciation, if the Chair would not rule me out of order and have me cast into the outer darkness of the room.

The CHAIRMAN. That request certainly is granted.

Senator HEINZ. Mr. Chairman, if I might say a few words about Gorham—most of us in Pennsylvania and a lot of the Nation owe him a deep debt of gratitude for his dedicated service to the elderly and the disadvantaged. He is a veteran of the U.S. Army, and after he graduated from the Army as a colonel, he went back to work in the private sector, working for a company that provided school lunches, ARA Services in Philadelphia.

In 1971, he began a 6-year term of service at HEW, as we called it then, Director of Region 3, headquartered in Philadelphia. In 1979, our Commonwealth of Pennsylvania established its first Department of Aging, and as its leader, as the Secretary of Aging in our State, he set a standard for innovation and leadership that others can only continue to envy.

Today, he is present as the Co-Chairman of the National Caucus and Center on the Black Aged, Incorporated, but that is only one of many hats he wears. His work with the American Association of Retired Persons, the National Association of State Units on Aging, the NAACP, and the National Urban League, are only a few examples of his wide-ranging efforts to help the elderly and disadvantaged, particularly minority elderly. His awards for his contributions in the field of aging would indeed fill a room, but I would like to take this opportunity to add yet another award to that room.

Gorham, on behalf of all your work for the elderly of Pennsylvania, I would like you to please accept this certificate of appreciation.

I would like to present it to him right down here, Mr. Chairman, if I might.

The CHAIRMAN. Go right ahead, Senator Heinz. [Applause.]

Thank you Senator Heinz.

Thank you, Gorham.

Senator SHELBY. Mr. Chairman?

The CHAIRMAN. Senator Shelby, yes.

Senator SHELBY. I do not have any award to give anyone. They all deserve it, but I have one gentleman from my hometown of Tuscaloosa, AL, Dr. Oscar Tucker, who is head of the Alabama Aging Commission. He is here in the audience and I just want to recognize him.

The CHAIRMAN. Dr. Tucker, we welcome you to the committee. [Applause.]

Thank you, Senator Shelby.

We have a statement from Senator Bradley of New Jersey, also, which we will include in the record of today's hearing at the appropriate place.

[The prepared statement of Senator Bradley follows:]

Bill Bradley

STATEMENT BY SENATOR BILL BRADLEY ON

PROFILES IN AGING AMERICA:

MEETING THE HEALTH CARE NEEDS OF THE NATION'S BLACK ELDERLY

BEFORE THE SENATE COMMITTEE ON AGING

SEPTEMBER 28, 1990

MR. CHAIRMAN AND CONGRESSMAN STOKES, I appreciate the efforts of the Black Caucus Health Brain Trust and the Senate Aging Committee to focus attention on the health needs of the black elderly population. We know that the greatest threat to the financial security of our senior citizens is the need for health care. The costs for health care are twice as high for those over age 65 compared to those under age 65. We also know that the likelihood of suffering from a chronic disease, such as heart condition, diabetes, and arthritis, dramatically increases as one approaches one's seventies or eighties. Even with coverage from medical insurance programs, including Medicare and Medicaid, additional expenses -- such as copayments and deductibles -- can devastate a family's savings in an alarmingly short period of time. And despite the efforts to expand and secure a comprehensive health care insurance system for all Americans, we are painfully aware that many of our citizens are unable, for a variety of reasons, to obtain adequate medical insurance.

There is another disturbing element to these sets of statistics: in every area - morbidity, chronic disease, access to health care services - the situation is far worse for our black elderly citizens. Although affording health care costs creates problems for all elderly citizens, the problems are worse for the black elderly. Recent data shows that the average income of black males age 65 was only about one-half of that for white males. Black elderly citizens are more than three times as likely to be living under the official poverty line than the white elderly. Nearly one-half of all black elderly citizens have incomes below reasonable poverty standards.

Obvious parallels occur between these income statistics and the quality and access to health care. For example, mortality rates have declined significantly during the last three decades due to medical advances in addressing heart disease and other medical conditions. Yet these improvements are considerably larger for older whites than for older blacks. The percentage of nursing home residents with Alzheimers' Disease or other age-related dementia is more than 10% higher for elderly blacks than for whites. Mortality rates across a broad range of conditions, from heart disease to cancer to pneumonia, each show the same disturbing consistency -- that the incidence rates are often significantly higher for the black elderly citizens than for other individuals.

All of this information points to a tremendous need for answers -- answers to why these discrepancies occur and what can be done to improve the health status of our black elderly citizens. I do know one thing that can be done today: an increase in the availability of home support and respite care services would enable our families to remain together and avoid the often unnecessary eventuality of stays in a nursing home. In New Jersey today, we have one such project that has had dramatic success providing badly-needed support services to over 2,000 families. I have also introduced legislation that would restore respite care benefits under Medicare that were unfortunately repealed with the Catastrophic Health Care Act. I will be fighting to gain prompt passage of this important measure.

I am sure that today's hearing will provide us with other important information that will lead to improvements in the quality and access to needed health care services for our elderly black citizens.

The CHAIRMAN. Now, we are in for a special treat. The Greater Washington Chapter of the Alzheimer's Association in collaboration with Howard University has produced a film that will be shown on Channel 32 in mid-October. We are going to see a 4- or 5-minute preview or segment of that film.

It is a documentary, a brainchild of a brilliant doctoral candidate at Howard University, Mr. Michael Fain. I am sorry to say that Mr. Fain could not be with us today, but his doctoral dissertation adviser, Dr. Joan Payne-Johnson, is on hand with a brief introduction.

Dr. Payne-Johnson, we welcome your introduction. Then we will dim the lights and have the film and serve the popcorn.

Ms. PAYNE-JOHNSON. Thank you, Senator Pryor, Mr. Stokes, and other distinguished members of the Committee.

My students and I are honored to have been asked to show a segment of their work at this historic joint hearing on minority health. The video which you are about to see is an excerpt from "Alzheimer's: A Family Affair," which will air in its entirety at 8 p.m., on October 11 and 14, over Howard University's Channel 32, WHMM. It is also scheduled to be aired on October 11 at Howard University's Annual Communications Conference.

Ms. Jacqueline Gill, who is here with me today, the producer, is a Master of Fine Arts, Film graduate student. She and Mr. Fain, a doctoral student in the Department of Communications Sciences and Disorders, conceived and produced this piece.

I am pleased to say that Mr. Fain is my doctoral student, whose dissertation is on Alzheimer's and communication loss. The interdisciplinary project of these two graduate students represents the first of its kind at our university and indeed in the country.

Mr. Fain's grandfather has Alzheimer's disease, and he is one of over 4 million persons in this country with the disease. Mr. Fain's interest in the disease compelled him to search the literature to understand Alzheimer's within his cultural context. He found few insights into family education and services for multicultural communities and no insights into cultural and linguistic diversity and communication loss secondary to Alzheimer's.

Our own literature in Communications Sciences and Disorders provides no clues about how normal black elderly use speech or language before catastrophic illness, and only one study in our literature has addressed a communication disorder in African-American elderly persons. Although this study was done on hearing loss, its compelling conclusion was that the severity of a particular health problem in the black community was influenced by the psychosocial, economic, and cultural milieu of the subjects.

This video then was born out of an acute need to address normal aging and the effects of Alzheimer's disease on African-American patients, their families, and their communities. In this segment, you will hear from researchers and service providers who specialize in the African-American elderly, and you will hear from family members who are on the front lines with this disease.

We wish to give credit to the Indiana University School of Medicine for its cooperation in filming Dr. Ozentaken's interview. We thank you for your attention.

The CHAIRMAN. Thank you, Dr. Payne-Johnson.

[Video presentation.]

Ms. PAYNE-JOHNSON. Thank you.

The CHAIRMAN. Thank you, Dr. Payne-Johnson, for an excellent presentation. Thank you very, very much. We salute all of you who have been a part of this film and we look forward to seeing the full documentary. It is a wonderful contribution.

Our first witness today was to be Dr. Joyce T. Berry, the Commissioner of the Administration on Aging, but she is unable to be with us today due to illness. I was very sorry that Dr. Berry could not be here. She was our special guest and chief witness at a recent hearing I held in Arkansas on problems confronting the elderly. We are very sorry that she cannot be here this morning. Filling in for Dr. Berry is Ms. Carol Crecy.

Ms. Crecy, please come forward to the witness table.

On all of our witnesses, we are going to impose what we call the 5-minute rule. This is not a gag rule. We are going to have each of your statements placed in the record in their entirety in full as if read completely, but if you would please help us on the 5-minute limitation on oral statements, we will have questions for the witnesses at the completion of those presentations.

We appreciate your being here today representing Dr. Berry.

## STATEMENT OF CAROL CRECY, ACTING DEPUTY ASSOCIATE COMMISSIONER FOR STATE AND COMMUNITY PROGRAMS, U.S. ADMINISTRATION ON AGING

Mr. CRECY. Good morning, Senator Pryor, Congressman Stokes, other members of the Committee on Aging. I am Carol Crecy, Acting Deputy Associate Commissioner for State and Community Programs at the Administration on Aging. It is a privilege to represent Dr. Joyce Berry, U.S. Commissioner on Aging who is unable to join you this morning because of illness.

As U.S. Commissioner on Aging, Dr. Berry is concerned with the well-being of every older American. However, I must acknowledge that certain vulnerable elders have special needs which may require particular attention from policymakers and those of us who administer programs for older Americans. This has been a congressionally mandated policy and it is a personal commitment of Dr. Berry's.

In this regard, one of Secretary Sullivan's first program directives that he proposed addressed the issues of health care and health status affecting minorities, first, by improving access to services for minority and low-income populations, and second, by reducing risk through early detection and treatment for chronic and preventable diseases and conditions that affect minority and low-income individuals disproportionately. This is not a directive to benefit only older Americans, but one which affects programs for minority persons of every age: children, adults, and the elderly.

Earlier this month, the Department of Health and Human Services held a conference at which a national strategy to improve the health of the Nation was unveiled. This strategy, referred to as "Healthy People 2000," focuses on opportunities to prevent premature death and needless disease and disability through prevention of major chronic illnesses, injuries, and infectious diseases. It is the

culmination of 3 years of national effort, led by the Public Health Service and supported by nearly 300 national organizations, every State health department, and more than 10,000 people throughout the country.

Healthy People 2000 represents a national commitment to improving the health of all Americans, especially those groups in our population which are in greater need, such as minority members. As Dr. Mason, Assistant Secretary for Health, has indicated:

> This set of objectives for the year 2000 makes an important compelling point to us and to all health policymakers—we can no longer afford not to invest in prevention. From the perspective of avoiding human suffering as well as saving wasteful costs for treating diseases and injuries that could have been prevented, the 1990's should be a decade of prevention in the United States.

Prevention is a lifelong process. Although it is commonly believed that health problems in old age are inevitable, many are in fact preventable or can be controlled. By changing certain risk behaviors into healthy ones, older persons can improve health and reduce the likelihood of disability. Improvements in diet, nutrition, increased physical activity, reductions in tobacco use and weight control can enhance the health of older people.

The Administration on Aging has demonstrated its commitment to health promotion, particularly as it relates to minority older persons, for many years. Through Title IV of the Older Americans Act, AOA has supported numerous research and demonstration projects to test innovative ways of providing health education, health promotion, and health care services to all older Americans. However, there are other factors which impact on the disparity of health status and health care of most minority propulations in the United States.

Socioeconomic status is one of the most compelling factors. Poverty and near poverty appear as underlying elements of many health problems experienced by these groups.

We know that members of minority groups are not only more likely to live near or below the poverty level, but are also likely to have a greater number of serious health problems at younger ages and to be more dependent on government-provided health care resources than nonminorities. Older black Americans, in particular, are judged to have poorer health status than aged white Americans by numerous standards of measurement. In addition, many of the health conditions experienced by black older persons may be lifestyle-related. High blood pressure, lung cancer, and diabetes are of special concern. Lack of adequate financial resources affects the ability of the black elderly to obtain necessary health care and to obtain a selection of nutritious food. It also may affect their ability to obtain needed services.

All of these factors point to the critical need for primary prevention activities prior to the age of onset. We need to change the attitudes and perceptions of the black elderly to make them more aware of the effects of smoking, obesity, and cholesterol. We need to focus attention on preventive measures and expand health promotion activities which will delay the need for costly health care. We must also focus our attention on the issue of access to services.

Although we have many challenges ahead, we continue to be committed to correcting the disparities between services provided

to minority and nonminority older persons. The Commissioner foresees a brighter future for tomorrow's older Americans. Healthier, better educated, and financially more secure, they will live longer and more rewarding lives.

Her optimism is due in part to continued congressional support for our Nation's most vulnerable elderly. Today's hearing, for instance, is evidence of your commitment to ensuring that all Americans are entitled to a healthy old age.

This ends my remarks. Thank you for the opportunity to participate in this hearing on the status of the black elderly.

[The prepared statement of Ms. Berry follows:]

Joyce T. Berry, Ph.D.

U.S. Commissioner on Aging

Testimony Before the Senate Special Committee on Aging

Joint Hearing on the Status of the Black Elderly

Members of the Committee and the Congressional Black Caucus Health Braintrust, thank you for inviting me to participate in this hearing on the status of black elderly. As U.S. Commissioner on Aging, I am concerned with the well-being of every older American. But I must also acknowledge that certain vulnerable older persons-- especially low-income minority elders--have special needs which may require particular attention from policy makers and those of us who administer programs for older persons. This has been Congressionally-mandated policy, and a personal commitment of my own.

In this regard, the Secretary of Health and Human Services has asked Under Secretary Constance Horner to oversee a comprehensive review of our public and private health and long term care financing and delivery. Additionally, one of the Secretary's first Program Directives proposed to address issues in health care and health status affecting minorities. First, by improving access to services for minority and low-income populations. Second, by reducing risk through early detection and treatment for chronic and preventable diseases and conditions that affect minority and low-income individuals disproportionately. This is not a directive to benefit only older Americans, but one which affects programs for minority persons of every age--children, adults, and the elderly.

Earlier this month, the Department held a conference at which a national strategy to improve the health of the nation was unveiled. This strategy--referred to as "Healthy People 2000"--focuses on opportunities to prevent premature death and

needless disease and disability through the PREVENTION of major chronic illnesses, injuries, and infectious diseases. It is the culmination of three years of national effort, led by the Public Health Service, and supported by nearly 300 national organizations, every State Health Department, and more than 10,000 persons throughout the country.

I shall not try to summarize the strategy detailed in the 700-page "Healthy People 2000" report, but I would like to share three major goals for the Nation that were identified:

1. Increase the span of healthy life for all Americans,
2. Reduce health disparities among Americans, and
3. Achieve access to preventive services for all Americans.

These goals reflect the concerns of the participants who contributed to the development of "Healthy People 2000" and recognize that progress toward a healthier America means a substantial improvement for certain populations that are at especially high risk--low-income groups, minority groups, and people with disabilities.

The report identifies significant risk factors. For nearly all leading chronic diseases, low income is a special risk factor. People with low income have death rates that are twice the rates for people with incomes above the poverty level.

Ethnicity is another risk factor. Since the mid-1980's, African Americans have experienced a slight decline in life expectancy, from a high of 69.7 years in 1984 to 69.4 years in 1987. Black men die from strokes at nearly twice the rate of men in the total population, and they experience a higher rate of cancer than non-black men. Diabetes and the complications of diabetes--heart disease, stroke, kidney failure, and blindness--are all more prevalent among blacks than whites. And statistics clearly demonstrate that black Americans do not receive enough early, routine, and preventive health care.

"Healthy People 2000" represents a national commitment to improving the health of all Americans, and especially those groups within our population which are in greater need, such as minority members. And as Dr. Mason, Assistant Secretary for

Health, has indicated - "This set of objectives for the year 2000 makes an important, compelling point to us and to all health policy makers: we can no longer afford not to invest in prevention. From the perspective of avoiding human suffering as well as saving wasteful costs for treating diseases and injuries that could have been prevented, the 1990s should be the decade of prevention in the United States."

Prevention is a life long process. Although it is commonly believed that health problems in old age are inevitable, many are in fact preventable or can be controlled. By changing certain risk behaviors into healthy ones, older persons can improve health and reduce the likelihood of disability. Improvements in diet and nutrition, reductions in tobacco use, and weight control can enhance the health of older people. Also, physical activity is a key ingredient to healthy aging. The Administration on Aging has demonstrated its commitment to health promotion, particularly as it relates to minority older persons, for many years. Through Title IV of the Older Americans Act, AoA has supported numerous Research and Demonstration projects to test innovative ways of providing health education, health promotion, and health care services to all older Americans. Sixteen grants valued at over $1 million have been awarded by AoA to various public and private institutions to improve the health status of elderly minorities since 1985.

The AoA-funded National Resource Centers on Health Promotion and Wellness, Long Term Care, Rural Elderly, and Minority Elderly provide information to State Units on Aging and help them work with professionals and the public to address the health care needs of vulnerable elders.

Last December, AoA awarded grants to 10 Historically Black Colleges and Universities to develop and implement programs related to health promotion for minority elderly. Although it is too early to judge the success of this effort, initial indications are promising.

Since 1982, AoA has provided grants totalling over $4 million to HBCUs, mostly for programs designed to strengthen gerontology training, research on elderly health problems, and the development of demonstration programs to improve services to our elderly minority citizens.

Within the next couple of days, the final decisions on grants funded under the Administration on Aging FY 1990 Discretionary Funds Program will be announced. I plan to award over one million dollars to State Agencies on Aging to develop or enhance State-wide planning efforts which result in expansion of in-home services for older persons, especially low-income minorities, frail elderly, older persons over age 80, and older women living alone.

Within the Department, AoA is working with the Public Health Service and Office of Minority Health to develop strategies to address the special needs of older minorities.

Through an initiative with the Public Health Service to improve rural and minority access to Community and Migrant Health Centers, we are trying to assist the black elderly and all rural minority elders by promoting greater access to and participation in primary care services available in these Centers.

I have also signed an interagency agreement with the National Institute on Aging to fund a major study of health promotion in the latter part of life. To address this problem, AoA is supporting projects in health promotion, nutrition, and delivery of health services that address the unique needs of racial and ethnic groups.

There are, however, other factors which impact on the disparity of health status and health care of most minority populations in the United States. Socioeconomic status is one of the most compelling factors. Poverty and near poverty appear as underlying elements of many health problems experienced by these groups.

We know that members of minority groups are not only more likely to live near or below the poverty level, they are also more likely to have a greater number of serious health problems at younger ages, and to be more dependent on government-provided health care resources than non-minorities.
Older black Americans, in particular, are judged to have poorer health than aged white Americans by numerous standards of measurement. In addition, many of the health conditions experienced by black older persons may be lifestyle-related -- high blood pressure, lung cancer, and diabetes are of special concern to minorities. Lack of adequate financial resources affects the ability of the black elderly to obtain necessary health care and to obtain a selection of nutritious food. It may also affect their ability to obtain needed services.

Since the establishment of Medicaid and Medicare in the mid 1960's, minority elders have had greater access to health care. Yet they have typically received less health care than white elderly persons.

All of these factors point to the critical need for primary prevention activities prior to the age of onset. We need to change the attitudes and perceptions of the black elderly, to make them more aware of the effects of smoking, obesity, and cholesterol. We need to focus attention on preventive measures--and expand health promotion activities which will delay the need for costly health care.

We also must focus our attention on the issue of access to services. Questions have been raised in the Congress and elsewhere concerning the participation rates of low-income minority older persons in Older Americans Act services. There is widespread support for expanding such participation beyond the current levels to implement to the fullest extent the letter and spirit of the Act.

State and Area Agencies on Aging are employing many strategies and methods to improve the participation level of low-income minority elderly in Older Americans Act programs. Their approaches include: hiring more minority staff; training of staff to improve sensitivity to and effectiveness with the minority elderly; placing the service delivery sites in

locations where they are more accessible to the target population; encouraging contracts and grants with minority firms and organizations for the provision of services; carefully monitoring the content and execution of area and service plans to assure a substantial effort and achievement in this area; revising the intra-state funding formula; and a number of other useful approaches.

At the Federal level, I have entered into a Memorandum of Understanding with Social Security Commissioner, Gwendolyn King, and HCFA Administrator, Gail Wilensky, to improve the coordination of Federal programs directed toward those in greatest need. For example, we are just concluding a pilot demonstration in 12 locations across the country in which Area Agencies on Aging regularly station paid staff or volunteers in SSA field offices to provide a variety of information and referral services and to assist older persons to access other public and private sector programs and services. We believe that this effort will demonstrate the viability and benefits of the "one-stop service" approach to information and referral services provided by the Department.

Additionally, we are working with SSA in its efforts to identify those most in need who may be eligible for Supplemental Security Income (SSI) and are not receiving these benefits.

Transportation is another factor which impacts on the ability of older minority persons to have adequate access to health care. Having health care available is meaningless if the older persons can't get to the health care provider. Although transportation is of concern to all older persons, it is especially important to the black elderly, many of whom live either in inner cities and find themselves confined to their homes because of the fear of crime or in rural areas with little or no public transportation.

Earlier this year, I signed a Memorandum of Understanding (MOU) with the Urban Mass Transportation Administration of the Department of Transportation. This MOU calls for increased

coordination between programs administered by AoA and UMTA. Our joint efforts will focus on assisting older persons, particularly low income and minority older persons residing in rural areas, to access needed health care and other vital services.

In conclusion, I believe that some progress is being made, but it has been slow and has been hampered to some extent by limited information about the health status of older black Americans. Limited data was identified by the developers of "Healthy People 2000" as an impediment to setting specific targets to narrow the gap between the total population and those groups that are at higher risk of death, disease, and disability. The "Healthy People 2000" report indicates that "Without data, targets cannot be set, even though professional consensus exists that a population group is at considerably higher risk than the total population. A challenge of the coming years is to build better data systems, at national and State levels, in order that the scope of health threats facing various groups within our society can be adequately defined and appropriate preventive interventions can be effectively focused."

Although we have many challenges ahead, we continue to be committed to correcting the disparities between service provided to minority and non-minority older persons. I foresee a brighter future for tomorrow's older Americans--healthier, better educated, financially more secure. They will live longer and more rewarding lives.

My optimism is due in part to continued Congressional support for our nation's most vulnerable elderly. Today's hearing, for instance, is evidence of your commitment to ensuring that all Americans are entitled to a healthy old age.

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The CHAIRMAN. We so appreciate your statement and your appearance here, especially on such short notice, before our Committee this morning. I only have a couple of very quick questions.

What role can the Administration on Aging play in giving a greater thrust to the sensitivity of the providers and the caregivers to the special needs of the black elderly? How can we raise that sensitivity level?

Ms. CRECY. We are doing several things at the Administration on Aging to do that, particularly in the area of health promotion. Just last December, we funded 10 grants to historically black colleges and universities to look at and test some innovative techniques for working with the black elderly in the area of health promotion.

We are also working with the State units on aging through a grant. They just recently held a meeting on strategies on how to work with minority elderly—not just black—and how to put into place strategies that would have minority persons better served in Older Americans Act programs.

The CHAIRMAN. Our studies are indicating that there is not just a disparity between the black elderly and the white elderly, but there is also a disparity between other ethnic groups. Next year in our Committee, we are going to hold additional hearings and increase our efforts here to sensitize this particular concern. Next year we will be holding additional hearings like this and probing what is happening, why it is happening, and what we can do about it.

Let me yield to Congressman Stokes.

Mr. STOKES. Thank you very much, Mr. Chairman.

Dr. Crecy, a very interesting phenomena is occurring with reference to the black elderly. As you know, over the last several years, blacks have experienced a decreasing life expectancy. At the same time, blacks die approximately 7 years earlier than whites. Yet we find that those blacks who do get into their eighties tend generally then, if they get into their eighties, to live longer than whites do, which is a very interesting anomaly.

I am wondering if the Agency is looking at this at all, because accompanying that, by blacks living longer, they are then enduring certain specific problems that the white generation is not experiencing. I wonder if you are looking at that problem?

Ms. CRECY. You will hear later on from Ms. Shirley Bagley of the National Institutes on Aging. They have been doing some research, and I think she will be able to shed more light and information on that particular question.

Mr. STOKES. Okay. I have just one other question.

We find that in the black community, female relatives tend to be the ones who give care to the black elderly in the home. That is, daughters and other female relatives. I am wondering if that is also something that you are looking into?

Ms. CRECY. Yes, we are particularly interested in caregivers. Women have traditionally been the caregivers for older persons. As you know, most women are now in the work place, so they have a dual burden of working full time as well as being the caregiver.

We are trying to get interventions and ways of helping those who are employed caregivers get relief from some of the stress and get

some of the assistance that they need to be a caregiver for older persons who in fact need that kind of help.

Mr. STOKES. Thank you very much.

Thank you Mr. Chairman.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Thank you, Senator Pryor.

Ms. Crecy, first of all I would like to let you know that I share completely your enthusiasm for the objectives of the "Healthy People 2000" strategy. Emphasizing preventive health care services is absolutely essential.

In your opinion, what steps do health professionals and communities need to take to implement these recommendations?

Ms. CRECY. One of the things that the Administration on Aging plans to do is to hold health promotion conferences in our regional offices. This is an opportunity for us to bring together the aging network and the health care network to talk about the particular concerns of health care for older Americans. We will be having nine of them in each of our regional office cities.

We have held one in New York just last year. This is one way that we plan to focus attention on this very important issue.

Senator KOHL. As I mentioned in my opening statement, fewer than 15 percent of eligible low-income blacks in my own city of Milwaukee took part in Older Americans Act nutrition programs in the first 3 months of this year. I understand that this kind of low participation rate is common across the country.

To your knowledge, have any cities effectively taken the steps you mentioned to improve participation levels?

Ms. CRECY. One of the first things that Commissioner Berry did when she became the U.S. Commissioner on Aging was to send out some policy guidance about targeting services to those who are in greatest social or economic need with particular attention to low-income minorities, focusing at this point on the intrastate funding formula to make sure that the money went to the communities that in fact had those who were in greatest need.

In addition, we have used our regional offices to work with the State agencies on aging to develop strategies. We are very committed to increasing the participation rates of minorities in Older Americans Act programs. We are working with them to develop strategies, not only the formula, but other ways of looking at what in fact are the barriers and what are the problems and why older minorities are not participating in the programs as we would expect them to do.

This is, again, a personal commitment of Dr. Berry's and we will be continuing throughout this year and throughout the next years, trying to come up with some innovative approaches. Dr. Berry also had a round table with a whole host of State and area agencies, service providers, and representatives from national minority aging organizations, about a year ago. They were all brought together as Senator Grassley said earlier, to try and put our brains and our trust together to try and come up with some solutions that work.

Senator KOHL. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Reid.

Senator REID. I have no questions, Mr. Chairman.

The CHAIRMAN. Thank you, our colleagues.

We thank you once again for coming. We may follow on with some written questions to you later on, and we would very much appreciate a response to those as we are trying to gather these facts and the information that we need.

Ms. CRECY. We will be pleased to answer any written questions you send. Than you very much.

The CHAIRMAN. Thank you.

Next, I would like to call a panel of four distinguished witnesses: Dr. Charles Johnson, Dr. Hazel Harper, Ms. C. Alicia Georges, and Dr. Wendell Hill. Would all of you please come to the witness table?

Dr. Charles Johnson is President of the National Medical Association, Durham, NC. Dr. Hazel Harper is President of the Robert T. Freeman Dental Society, representing the National Dental Association from Washington, DC. Alicia Georges is President of the National Black Nurses' Association from New York City. Dr. Wendell Hill is President of the National Pharmaceutical Association of Washington, DC.

We thank all of you for appearing today. We look forward to your statements. Once again, please help us with the 5-minute rule this morning.

We will start, Dr. Johnson, with you.

## STATEMENT OF CHARLES JOHNSON, PRESIDENT, NATIONAL MEDICAL ASSOCIATION, DURHAM, NC

Dr. JOHNSON. Good morning, Senator Pryor, Chairman Stokes, distinguished members of the panel. Thank you for this opportunity to submit testimony to your committees regarding how best to accomplish the goal of meeting the health care needs of our Nation's black elderly.

As president of the National Black Medical Association and as a practicing internist, I am here on behalf of a 95-year-old professional organization which represents over 16,000 physicians from throughout the United States, the Virgin Islands, and Puerto Rico, who are among the primary providers to the medically underserved and low-income minority populations. The majority of NMA members are African-American physicians. However, we welcome as active participants any health care professional who is interested in promoting the science of medicine and better health care for all Americans.

Today I will focus on the problems facing NMA member health care providers in caring for the African-American elderly, specifically, the vital statistics, the significance of the problem, the diseases that represent the greatest threat, the status and need to strengthen Federal health care programs, such as Medicare, the issues of financing long-term care for the elderly, and NMA's recommendations to address these vexing problems.

In 1988, the overall elderly population in the United States consisted of 18 million women and approximately 12 million men. Persons reaching 65 years of age have an average life expectancy of 16.9 additional years. One in nine Americans is over the age of 60, and that population is continuing to grow.

This growth should be relatively small during the 1990's because of the small number of babies born during the Depression era. However, a rapid increase is expected between the years 2010 and 2030 when the baby boom generation reaches age 65.

The African-American elderly community is currently the fastest growing segment of the total African-American population. Between 1970 and 1980, the African-American population increased by 34 percent, whereas the total population of the United States increased by only 16 percent.

Data from the U.S. Census Bureau indicates that as of March 1988, 2 million African-Americans were over the age of 55. One million were over age 65, and approximately 900,000 were over age 75. It is projected that by the year 1999, the number of African-Americans over the age of 65 will increase to 3 million.

African-Americans have and continue to be victims of adverse economic and social conditions. The elderly community is particularly susceptible to problems associated with these societal ills. Economically, African-Americans generally have less personal postretirement income than their white counterparts and are more dependent upon Social Security benefits for the majority of their retirement income.

Most recently, the Department of Health and Human Services released the "Healthy People 2000" national health promotion and disease prevention objectives. In this report, it was revealed that the leading causes of death among people age 65 and older were heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia, and influenza. It was further noted that health problems such as osteoporosis, arthritis, incontinence, dementia, and visual or hearing impairments, although not common causes of death, have a significant effect on the quality of life.

There are many factors which may explain some of these alarming trends from a scientific standpoint, but history will ultimately judge our generation on our ability to effectively address the technological problems of health care at a time when there are competing demands to limit governmental expenditures in all arenas including that of health care delivery. Various tax revolts throughout the Nation, the growing Federal deficit, and, as we meet, the budget negotiators' appearance of a deadlock on a plan to allocate our Nation's expenditures, make it abundantly clear that we must wisely spend our precious tax dollars that must give us the best bang for our buck, particularly in the health care arena.

The number one problem facing the elderly population as a whole is heart disease. While heart disease remains a strong contributor to poor health and death among the elderly in the general population and there has been a marked decline in the death rates from this disease, this has not been true of the African-American population.

The death rate for esophageal cancer is 10 times higher for African-American men. We have a 25-percent higher incidence of cancer, with cancer of the lungs, prostate, stomach, pancreas, and colon being frequent. Breast cancer is also highly prevalent in African-American women.

While high blood pressure affects more than 28 of every 100 white adults, it affects more than 38 of every 100 African-Ameri-

cans. One in three African-Americans has hypertension, while African-American women over the age of 65 are more at risk than any other group in the United States.

Today there are 17 million women over the age of 65. Many of these women suffer from inadequate health care because of the lack of research concerning the health of older women, misunderstandings and ignorance of older women's needs, and a disproportionately high level of limited insurance coverage. While women comprise 59 percent of the population over 65, they make up 72 percent of the elderly poor. One-third of older single women rely on Social Security benefits for at least 90 percent of their income. In 1986, it was reported that 35 percent of older African-American women and 25 percent of older Hispanic women lived in poverty.

The NMA was supportive and endorsed the original implementation of the Medicare program in the 1960's, and at that time, was the only national medical organization to do so both publicly and enthusiastically. Although history has taught that to the victor belongs the spoils, with Medicare as with many other programs, the NMA and those we represent have received fewer benefits than those who were in opposition.

Current projections reveal that by the end of 1990, 30 million elderly Americans will receive Medicare benefits in some manner. Both Part A and Part B of Medicare require recipients to pay deductibles and coinsurance amounts. Deductibles and coinsurance are not based on ability to pay. Therefore, a greater financial burden is still placed on the elderly, particularly those in poverty. Here, too, since a higher proportion of the African-American elderly population is composed of lower income individuals including those in poverty, who as noted above, rely more heavily on Social Security and Medicare, the absence of a plan based on the ability to pay under these programs most adversely affects this population.

As you know, Mr. Chairman, most elderly individuals would rather be cared for in the home than in a hospital or in a nursing home. The high cost of institutionalization far exceeds the cost of providing quality homebound care.

The Bush administration's fiscal year 1991 budget continues to target budget reductions disproportionately higher on physician and other services that reduce the elderly's ability to receive home care. The NMA is opposed to any further budget reductions to the Medicare and Medicaid programs that would prevent African-American elderly patients from being able to remain in their homes and to receive adequate quality medical care.

The African-American elderly often experience great difficulty obtaining access to a quality nursing home facility due to their limited income. Once they do obtain a bed in a facility, the nursing home is often many miles away from relatives, friends, and loved ones. Consequently, institutionalization for African-American elderly often further isolates them from their family members.

The NMA's Quality Assurance Task Force made a series of recommendations. One, Medicare and home health agencies need to utilize innovative approaches to provide quality home health care to the elderly African-Americans directly, including paid escorts and hazardous duty compensation to staff, both of which would in-

crease availability of homebound services to elderly African-Americans in poorer, crime-ridden neighborhoods. Two, improve education to African-American patients to assure better understanding of how to obtain home health medical service in the existing fragmented health care delivery system. Three, Medicaid programs must reduce burdensome requirements that limit the patient's access to vital medications on a monthly basis.

In the area of drug treatment, quality care should not be sacrificed due to budgetary restraints which result in the poor and elderly receiving therapeutically substituted drugs as a means to reduce Medicaid expenditures. In June of this year, the Office of Management and Budget proposed to the budget summit conferees a plan to include classifying drugs and selecting the least expensive drug in each class as the preferred drug. The NMA recognizes the inherent and real danger in utilizing cost alone to substitute a medication prescribed by a physician who has personally examined the patient and written a prescription based upon the individual patient's entire medical history and health milieu.

Dispensing medication to Medicaid recipients based solely on price creates another objectionable distinction in medical service provided to the poor, many of whom are African-American or other minorities. The NMA is opposed to this treatment of Medicaid recipients that is clearly discriminatory and assigns a diminished value of life to this group of disadvantaged patients. A new low would have been reached if this new form of disparate treatment is permitted.

The availability of health care resources for the chronically ill, most of whom are over 65 years of age, remains a major public policy concern. This is particularly true because many African-American elderly have a mistaken impression that the expenses of chronic illnesses are covered by the existing Medicare program. Many others believe that their retirement private health insurance plans will adequately cover long-term care expenses. They fail to realize——

Mr. STOKES [assuming chair]. Dr. Johnson, let me interrupt you for a moment. If we are to remain on schedule, I am going to have to insist upon the 5-minute rule being followed.

We are going to put into the record your entire statement. The recorder here will have your entire statement for the purposes of a transcript. If each of you would summarize within the 5-minute rule, I would appreciate it.

When we are in hearings and Members are speaking, we have to adhere to these lights here under the 5-minute rule. You get a green light when you first start; an auburn light means you have about one minute to wrap up, and then the red light signals the end of your 5 minutes.

Dr. JOHNSON. May I summarize then?

Mr. STOKES. If you would just sum up for me now, I would appreciate it.

Dr. JOHNSON. In conclusion, Mr. Chairman, it is imperative that the President of the NMA bring to your attention a very serious breach in our health care delivery system which will impact the elderly and other Americans served negatively. We are beginning to lose physicians out of the practice of medicine at an alarming rate

in ghettos and underserved areas both rural and urban primarily because of inadequate reimbursement. The NMA is currently in the process of defining on a national basis the extent and causes of a loss of physician practices. Once we have this data is hand, we will most likely have to come before the appropriate congressional committees to seek legislation for correction of the loss of so valuable a human resource: physicians, expecially those who serve in ghettos and underserved areas.

Finally, let me emphasize that the NMA stands ready to assist the Congress in structuring effective programs that lead to an improved health care delivery system for all Americans, but especially for the elderly.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Johnson follows:]

TESTIMONY OF DR. CHARLES JOHNSON
PRESIDENT
NATIONAL MEDICAL ASSOCIATION

BEFORE A JOINT HEARING OF THE
CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST
AND
SENATE SPECIAL COMMITTEE ON AGING

GOOD MORNING CHAIRMAN STOKES, CHAIRMAN PRYOR AND DISTINGUISHED MEMBERS OF THE PANEL.

I. INTRODUCTION

THANK YOU FOR THIS OPPORTUNITY TO SUBMIT TESTIMONY TO YOUR COMMITTEES REGARDING HOW BEST TO ACCOMPLISH THE GOAL OF MEETING THE HEALTH CARE NEEDS OF OUR NATION'S BLACK ELDERLY. AS PRESIDENT OF THE NATIONAL MEDICAL ASSOCIATION ("NMA") AND AS A PRACTICING INTERNIST, I AM HERE ON BEHALF OF AN ORGANIZATION WHICH REPRESENTS OVER 16,000 PHYSICIANS FROM THROUGHOUT THE UNITED STATES, THE VIRGIN ISLANDS AND PUERTO RICO, WHO ARE AMONG THE PRIMARY PROVIDERS TO THE MEDICALLY UNDERSERVED AND LOW INCOME MINORITY POPULATIONS. THE MAJORITY OF NMA MEMBERS ARE AFRICAN-AMERICAN PHYSICIANS, HOWEVER, WE WELCOME AS ACTIVE PARTICIPANTS ANY HEALTH CARE PROFESSIONAL, WHO IS INTERESTED IN PROMOTING THE SCIENCE OF MEDICINE AND BETTER HEALTH CARE FOR ALL AMERICANS.

TODAY, I WILL FOCUS ON THE PROBLEMS FACING NMA MEMBER HEALTH CARE PROVIDERS IN CARING FOR THE AFRICAN-AMERICAN ELDERLY. SPECIFICALLY, THE VITAL STATISTICS, THE SIGNIFICANCE OF THE PROBLEM; THE DISEASES THAT REPRESENT THE GREATEST THREAT; THE STATUS AND NEED TO STRENGTHEN FEDERAL HEALTH CARE PROGRAMS, SUCH AS OF MEDICARE; THE ISSUES OF FINANCING LONG-TERM CARE FOR THE ELDERLY; AND NMA'S RECOMMENDATIONS TO ADDRESS THESE VEXING PROBLEMS.

II. VITAL STATISTICS

IN 1988, THE OVERALL ELDERLY POPULATION IN THE UNITED STATES CONSISTED OF EIGHTEEN MILLION WOMEN AND APPROXIMATELY TWELVE MILLION MEN. PERSONS REACHING 65 YEARS OF AGE HAVE AN AVERAGE LIFE EXPECTANCY OF 16.9 ADDITIONAL YEARS. ONE IN NINE AMERICANS IS OVER THE AGE OF SIXTY, AND THAT POPULATION IS CONTINUING TO GROW. THIS GROWTH SHOULD BE RELATIVELY SMALL DURING THE 1990'S BECAUSE OF THE SMALL NUMBER OF BABIES BORN DURING THE DEPRESSION ERA; HOWEVER, A RAPID INCREASE IS EXPECTED BETWEEN THE YEARS 2010 AND 2030, WHEN THE "BABY BOOM" GENERATION REACHES AGE 65.

THE AFRICAN-AMERICAN ELDERLY COMMUNITY IS CURRENTLY THE FASTEST GROWING SEGMENT OF THE TOTAL AFRICAN-AMERICAN POPULATION. BETWEEN 1970 AND 1980, THE AFRICAN AMERICAN POPULATION INCREASED BY 34 PERCENT, WHEREAS THE TOTAL POPULATION OF THE UNITED STATES INCREASED BY ONLY 16 PERCENT. DATA FROM THE UNITED STATES CENSUS BUREAU INDICATES THAT AS OF MARCH 1988, TWO MILLION AFRICAN-AMERICANS WERE OVER AGE 55, ONE MILLION OVER AGE 65, AND APPROXIMATELY NINE HUNDRED THOUSAND WERE OVER AGE 75. IT IS PROJECTED THAT BY THE YEAR 1999, THE NUMBER OF AFRICAN-AMERICANS OVER THE AGE OF 65 WILL INCREASE TO THREE MILLION.

AFRICAN-AMERICANS HAVE AND CONTINUE TO BE VICTIMS OF ADVERSE ECONOMIC AND SOCIAL CONDITIONS, AND THE ELDERLY COMMUNITY IS PARTICULARLY SUSCEPTIBLE TO PROBLEMS ASSOCIATED WITH THESE SOCIETAL ILLS. ECONOMICALLY, AFRICAN-AMERICANS GENERALLY HAVE LESS PERSONAL POST-RETIREMENT INCOME THAN THEIR WHITE COUNTERPARTS, AND ARE MORE DEPENDENT ON SOCIAL SECURITY BENEFITS FOR THE MAJORITY OF THEIR RETIREMENT INCOME. THE MEDIUM INCOME OF THE AFRICAN-AMERICAN ELDERLY IS CONSIDERABLY LESS THAN THAT OF THE WHITE ELDERLY, I.E., $4113 FOR AFRICAN-AMERICAN MEN; $2825 FOR AFRICAN-AMERICAN WOMEN; AS COMPARED TO $7,408 FOR WHITE MEN AND $3,894 FOR WHITE WOMEN.

GEOGRAPHICALLY, APPROXIMATELY ONE-FIFTH OF THE AFRICAN-AMERICAN ELDERLY LIVE IN RURAL AREAS AS COMPARED TO A SOMEWHAT LOWER PROPORTION THAN WHITE ELDERLY (ABOUT ONE-FOURTH). IN THESE RURAL AREAS, ONE IN EVERY TWO AFRICAN-AMERICAN ELDERLY LIVES IN POVERTY. BROKEN DOWN BY SEX, ALMOST TWO-THIRDS OR 68 PERCENT OF AFRICAN AMERICAN WOMEN ARE IN OR NEAR POVERTY, AS COMPARED TO 40 PERCENT OF WHITE WOMEN. IN URBAN AREAS, ONE IN THREE OF EVERY AFRICAN-AMERICAN ELDERLY LIVES IN POVERTY, AS COMPARED TO A RATIO OF ONE IN NINE BY THE ELDERLY WHITE COMMUNITY.

IN TERMS OF MORTALITY, AFRICAN-AMERICANS HAVE A LIFE EXPECTANCY OF 69.6 YEARS COMPARED TO 75.2 YEARS FOR WHITES--A GAP OF OVER FIVE YEARS WHICH CONTINUES TO DEMONSTRATE THE EXCESS DEATHS OCCURRING AMONG AFRICAN-AMERICANS WHICH HAS BEEN WELL DOCUMENTED IN THE HECKLER REPORT OF 1984, WHICH HAS NOT BEEN SERIOUSLY ADDRESSED IN ANY MEANINGFUL WAY TO THIS DATE. ALTHOUGH AFRICAN-AMERICANS WHO REACH THE AGE OF 70 ENJOY A HIGHER SURVIVAL RATE THAN WHITES, THEY USUALLY SUFFER FROM HIGHER RATES OF POVERTY AND ILLNESS.

## III. SIGNIFICANCE OF THE PROBLEM

MOST RECENTLY, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELEASED THE HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES. IN THIS REPORT, IT WAS REVEALED THAT THE LEADING CAUSES OF DEATH AMONG PEOPLE AGES 65 AND OLDER ARE HEART DISEASE, CANCER, STROKE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, PNEUMONIA, AND INFLUENZA. IT WAS FURTHER NOTED THAT HEALTH PROBLEMS SUCH AS OSTEOPOROSIS, ARTHRITIS, INCONTINENCE, DEMENTIA, AND VISUAL OR HEARING IMPAIRMENTS, ALTHOUGH NOT COMMON CAUSES OF DEATH, HAVE A SIGNIFICANT EFFECT ON THE QUALITY OF LIFE.

THERE ARE MANY FACTORS WHICH MAY EXPLAIN SOME OF THESE ALARMING TRENDS FROM A SCIENTIFIC STANDPOINT, BUT HISTORY WILL ULTIMATELY JUDGE OUR GENERATION ON OUR ABILITY TO EFFECTIVELY ADDRESS THE TECHNOLOGICAL PROBLEMS OF HEALTH CARE AT A TIME WHEN THERE ARE COMPETING DEMANDS TO LIMIT GOVERNMENTAL EXPENDITURES IN ALL ARENAS, INCLUDING THAT OF HEALTH CARE DELIVERY. VARIOUS TAX REVOLTS THROUGHOUT THE NATION, THE GROWING FEDERAL DEFICIT AND, AS WE MEET, THE BUDGET NEGOTIATOR'S APPEARANCE OF A DEADLOCK ON A PLAN TO ALLOCATE OUR NATION'S EXPENDITURES--MAKE IT ABUNDANTLY CLEAR THAT WE MUST WISELY SPEND OUR PRECIOUS TAX DOLLARS ON PROGRAMS THAT MUST GIVE US THE BEST "BANG FOR OUR BUCK," PARTICULARLY IN THE HEALTH CARE ARENA.

AT THIS JUNCTURE, LET US REVIEW THE PARTICULAR IMPACT OF SOME OF THE LEADING KILLERS ON THE TARGET POPULATION.

### A. HEART DISEASE

THE NUMBER ONE HEALTH PROBLEM FACING THE ELDERLY POPULATION, AS A WHOLE, IS HEART DISEASE. A SENATE SPECIAL COMMITTEE ON AGING REPORTED THAT HEART DISEASE ACCOUNTED FOR 10 PERCENT OF ALL DOCTOR VISITS, 18 PERCENT OF SHORT-STAY HOSPITAL

AND BED DISABILITY DAYS, AND 45 PERCENT OF ALL DEATHS IN 1980. A LARGE NUMBER OF THE 750,000 AMERICANS WHO DIE EACH YEAR OF HEART DISEASE ARE ELDERLY.

WHILE HEART DISEASE REMAINS A STRONG CONTRIBUTOR TO POOR HEALTH AND DEATH AMONG THE ELDERLY IN THE GENERAL POPULATION. THERE HAS GENERALLY BEEN A MARKED DECLINE IN DEATH RATES FROM THIS DISEASE BUT THIS HAS NOT BEEN TRUE OF THE AFRICAN-AMERICAN POPULATION. THE DECREASE COULD BE THE RESULT OF THE PUBLIC AWARENESS OF THE LINK BETWEEN DIETARY FAT AND HEART DISEASE. A NATIONAL SURVEY RECENTLY REVEALED THAT PUBLIC AWARENESS ROSE FROM 45 PERCENT IN 1982 TO 80 PERCENT IN THE MID-1990'S; HOWEVER, THE REPORT ALSO SHOWED THAT THERE STILL REMAINS MISUNDERSTANDINGS ABOUT THE TERMS "FAT" AND CHOLESTEROL". FOR EXAMPLE, ONLY 29 PERCENT OF THE SURVEYED POPULATION KNEW THAT A PRODUCT CHARACTERIZED AS "CHOLESTEROL FREE" COULD STILL BE HIGH IN SATURATED FAT. THESE FACTORS AS WELL AS THE TRADITIONAL ETHNIC EATING HABITS OF THE TARGET POPULATION COULD BE AN EXPLANATION FOR THE ABSENCE OF A DECLINE IN THE DISEASE AMONG AFRICAN-AMERICAN ELDERLY. ALSO, WE MUST REMIND YOU THAT ONE'S SOCIOECONOMIC STATUS PLAYS A SIGNIFICANT ROLE IN DETERMINING THE TYPES AND QUANTITIES OF FOODS PURCHASED. MANY OF THOSE FOODS HAVE THE POTENTIAL TO IMPACT NEGATIVELY WHEN EATEN WITHOUT REGARD TO PROPER DISTRIBUTION OF CALORIES. THUS, THERE APPEARS TO BE A PARTICULAR NEED FOR BETTER EDUCATIONAL PROGRAMS FOCUSED ON THIS POPULATION, IF WE ARE TO OBTAIN EQUIVALENT ADVANCES IN REVERSING THE NEGATIVE TREND IN THE TARGET POPULATION.

B. CANCER AND HIGH BLOOD PRESSURE

THE DEATH RATE FOR ESOPHAGEAL CANCER IS TEN TIMES HIGHER FOR AFRICAN-AMERICAN MEN. WE HAVE A 25 PERCENT HIGHER INCIDENCE OF CANCER, WITH CANCER OF THE LUNGS, PROSTRATE, STOMACH, COLON AND PANCREAS BEING MORE FREQUENT. BREAST CANCER IS ALSO HIGHLY PREVALENT IN AFRICAN-AMERICAN WOMEN.

WHILE HIGH BLOOD PRESSURE AFFECTS MORE THAN 28 OUT OF EVERY 100 WHITE ADULTS, IT AFFECTS MORE THAN 38 OUT OF EVERY 100 AFRICAN-AMERICANS. ONE IN THREE AFRICAN-AMERICANS HAS HYPERTENSION, WHILE AFRICAN-AMERICAN WOMEN OVER THE AGE OF 65 ARE MORE AT RISK THAN ANY OTHER GROUP IN THE UNITED STATES.

C. SPECIAL PROBLEMS OF AFRICAN-AMERICAN WOMEN

TODAY, THERE ARE 17 MILLION WOMEN OVER THE AGE OF 65. MANY OF THESE WOMEN SUFFER FROM INADEQUATE HEALTH CARE BECAUSE OF THE LACK OF RESEARCH CONCERNING THE HEALTH OF OLDER WOMEN, MISUNDERSTANDINGS AND IGNORANCE OF OLDER WOMEN'S NEEDS, AND A DISPROPORTIONATELY HIGH LEVEL OF LIMITED INSURANCE COVERAGE.

WHILE WOMEN COMPRISE 59 PERCENT OF THE POPULATION OVER 65, THEY MAKE UP 72 PERCENT OF THE ELDERLY POOR. ONE-THIRD OF OLDER SINGLE WOMEN RELY ON SOCIAL SECURITY BENEFITS FOR AT LEAST 90 PERCENT OF THEIR INCOME. IN 1986, IT WAS REPORTED THAT 35 PERCENT OF OLDER AFRICAN-AMERICAN WOMEN AND 25 PERCENT OF OLDER HISPANIC WOMEN LIVED IN POVERTY. MEDICARE PAYS ONLY 33 PERCENT OF MEDICAL BILLS FOR SINGLE WOMEN.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORTED THAT THE AVERAGE AMERICAN WOMAN WITH A LIFE EXPECTANCY OF 85 YEARS HAS A ONE IN TEN CHANCE OF GETTING BREAST CANCER. WHILE MANY OLDER WOMEN BELIEVE THAT THEY HAVE TO WORRY LESS ABOUT GETTING THIS DISEASE AS THEY AGE, THE FACT IS, 80 PERCENT OF ALL BREAST CANCERS OCCUR IN POST-MENOPAUSAL WOMEN. DESPITE THESE STATISTICS, EARLY DETECTION ALLOWS MORE OPTIONS AND PRESENTS A BETTER PROGNOSIS FOR WOMEN DIAGNOSED WITH BREAST CANCER. YET A STUDY BY THE AMERICAN CANCER SOCIETY SHOWED THAT LESS THAN 50 PERCENT OF PHYSICIANS REFER WOMEN OVER 40 FOR A MAMMOGRAM. PERIODIC MAMMOGRAM SCREENING, HOWEVER, IS NOT A BENEFIT COVERED UNDER MEDICARE. IT IS IMPORTANT THAT OLDER WOMEN ASK THEIR PHYSICIAN FOR A MAMMOGRAM, AND, IF POSSIBLE, GET ONE THROUGH AVAILABLE COMMUNITY PROGRAMS. THE PARTICULAR DIFFICULTY AS RELATES TO ELDERLY AFRICAN-AMERICAN WOMEN IS THAT SINCE A DISPROPORTIONATELY HIGH NUMBER OF THESE INDIVIDUALS ARE DRAWN FROM THE LOWER ECONOMIC SECTOR OF THE POPULATION, THEY ARE LESS LIKELY TO HAVE COMPETENT, REGULAR MEDICAL ADVICE, CARE AND ATTENTION.

THE AMERICAN CANCER SOCIETY ALSO REPORTS THAT THERE IS AN INCREASE IN THE INCIDENCE OF LUNG CANCER AMONG WOMEN, TO THE EXTENT THAT IT HAS SURPASSED BREAST CANCER. ADDITIONALLY, HEART DISEASE WHICH I MENTIONED EARLIER AS THE NUMBER ONE HEALTH PROBLEM FACING THE ELDERLY, IS THE LEADING CAUSE OF DEATH AMONG WOMEN. PREVIOUSLY THOUGHT TO BE A MAN'S PROBLEM, STATISTICS REVEAL THAT 350,000 OF THE 750,000 AMERICANS WHO DIE EACH YEAR OF HEART DISEASE ARE WOMEN. ALL OF THESE AILMENTS CONTINUE TO ADVERSELY AFFECT ELDERLY AFRICAN-AMERICAN FEMALES AT A GREATER RATE THAN IT DOES THEIR WHITE COUNTERPARTS.

## IV. MEDICARE

### A. STATUS AND NEED TO STRENGTHEN PROGRAM

NMA WAS SUPPORTIVE AND ENDORSED THE ORIGINAL IMPLEMENTATION OF THE MEDICARE PROGRAM IN THE 1960'S, AND AT THAT TIME WAS THE ONLY NATIONAL MEDICAL ORGANIZATION TO DO SO PUBLICLY AND ENTHUSIASTICALLY. ALTHOUGH HISTORY HAS TAUGHT THAT TO THE VICTOR BELONGS THE SPOILS, WITH MEDICARE AS WITH OTHER PROGRAMS, THE NMA AND THOSE WE REPRESENT HAVE RECEIVED FEWER BENEFITS THAN THOSE WHO WERE IN OPPOSITION.

CURRENT PROJECTIONS REVEAL THAT BY THE END OF 1990, 30 MILLION ELDERLY AMERICANS WILL RECEIVE MEDICARE BENEFITS IN SOME MANNER. AS YOU KNOW, MEDICARE CONSISTS OF TWO TRUSTS THAT PAY FOR THE ACUTE CARE COSTS OF THE ELDERLY, THE HOSPITAL INSURANCE TRUST, (ALSO KNOWN AS PART A OF MEDICARE), AND THE SUPPLEMENTARY MEDICAL INSURANCE TRUST (PART B). ACCORDING TO THE PRESIDENT'S BUDGET FOR FISCAL YEAR 1991, THE HOSPITAL TRUST IS EXPECTED TO SPEND $63 BILLION FOR HOSPITAL AND RELATED CARE COSTS OF INDIVIDUALS OVER THE AGE OF 65, AND OF THE PERMANENTLY DISABLED. THIS TRUST IS FINANCED PRIMARILY THROUGH SOCIAL SECURITY PAYROLL TAX CONTRIBUTIONS PAID BY EMPLOYERS, EMPLOYEES, AND THE SELF-EMPLOYED. THE HOSPITAL INSURANCE TRUST HAS HAD A SURPLUS FOR MANY YEARS, AND ITS INCOME IS EXPECTED TO EXCEED OUTLAYS BY $26 BILLION IN 1991. HOWEVER, THIS SURPLUS IS DUE IN LARGE PART TO THE TEMPORARY PRESENCE OF THE BABY BOOM GENERATION IN THE TAXPAYING WORK FORCE. IT IS PROJECTED THAT THIS TRUST FUND WILL BE DEPLETED AFTER THE TURN OF THE CENTURY WHEN THE BABY BOOM GENERATION BEGINS TO RETIRE.

IN 1991, THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND IS ESTIMATED TO SPEND $47 BILLION FOR PHYSICIAN SERVICES AND OTHER MEDICAL EXPENSES OF THE ELDERLY AND DISABLED. UNLIKE THE HOSPITAL INSURANCE TRUST, FINANCING UNDER THIS TRUST IS ESTABLISHED ANNUALLY, AND DEPENDS ON WHETHER ASSETS ARE SUFFICIENT TO COVER LIABILITIES EXPECTED TO BE INCURRED BY THE END OF THE YEAR. FINANCING IS DERIVED FROM PREMIUMS PAID BY THE BENEFICIARIES, AND PAYMENTS FROM GENERAL REVENUE.

BOTH PART A AND PART B OF MEDICARE REQUIRES RECIPIENTS TO PAY DEDUCTIBLES AND COINSURANCE AMOUNTS. DEDUCTIBLES AND COINSURANCE ARE NOT BASED ON ABILITY TO PAY, THEREFORE, A GREATER FINANCIAL BURDEN IS STILL PLACED ON THE ELDERLY, PARTICULARLY THOSE IN POVERTY. HERE TO, SINCE A HIGHER PROPORTION OF THE

AFRICAN-AMERICAN ELDERLY POPULATION IS COMPOSED OF LOWER INCOME INDIVIDUALS INCLUDING THOSE IN POVERTY, WHO AS NOTED ABOVE RELY MORE HEAVILY ON SOCIAL SECURITY AND MEDICARE. THE ABSENCE OF A PLAN BASED "ON THE ABILITY TO PAY" UNDER THESE PROGRAMS MOST ADVERSELY EFFECTS THIS POPULATION.

B. HOMEBOUND AND NURSING HOME CARE

AS YOU KNOW, MESSRS. CHAIRMAN, MOST ELDERLY INDIVIDUALS WOULD RATHER BE CARED FOR IN THE HOME THAN IN A HOSPITAL AND/OR NURSING HOME. THE HIGH COST OF INSTITUTIONALIZATION FAR EXCEEDS THE COSTS OF PROVIDING QUALITY HOMEBOUND CARE. LIKEWISE, WE OF THE NMA WOULD LIKE TO PUT MORE EMPHASIS ON HOMEBOUND CARE NOT ONLY BECAUSE IT IS LESS EXPENSIVE, BUT BECAUSE IT IS ALSO LESS DISTURBING TO SENIOR CITIZENS WANING COGNITIVE AND COPING ABILITIES AND THEIR INTENSE DESIRE TO REMAIN INDEPENDENT. THE BUSH ADMINISTRATION'S FISCAL YEAR 1991 BUDGET CONTINUES TO TARGET BUDGET REDUCTIONS DISPROPORTIONATELY HIGHER ON PHYSICIAN AND OTHER SERVICES THAT REDUCE THE ELDERLY'S ABILITY TO RECEIVE HOME CARE. THE NMA IS OPPOSED TO ANY FURTHER BUDGET REDUCTIONS TO THE MEDICARE AND MEDICAID PROGRAMS THAT WOULD PREVENT AFRICAN-AMERICAN ELDERLY PATIENTS TO REMAIN IN THEIR HOMES AND TO RECEIVE ADEQUATE QUALITY MEDICAL CARE.

SINCE 1983, THROUGH THE PROSPECTIVE PAYMENT SYSTEM MEDICARE IS PRESSURING HOSPITALS TO DISCHARGE PATIENTS EARLIER, AND OFTEN SICKER, THAN BEFORE. THE USE OF NEW MEDICAL TECHNOLOGIES SUCH AS VENTILATORS, NUTRITIONAL FEEDINGS AND CHEMOTHERAPY RECENTLY HAVE BEEN DEVELOPED WHICH MAKES THIS ALL POSSIBLE.

HOWEVER, SINCE THE HOSPITALS ARE DISCHARGING PATIENTS EARLIER, SUFFICIENT NURSING HOME BEDS ARE UNAVAILABLE SO MANY PATIENTS MUST RETURN HOME. NMA MEMBERS ARE CARING FOR MORE MEDICARE PATIENTS AT HOME. MEDICARE PATIENTS NOW NEED TO RECEIVE IMPROVED QUALITY OF HOMEBOUND CARE.

CHAIRMEN, AS THE AFRICAN-AMERICAN ELDERLY GET OLDER MANY OF THEM HAVE HEALTH PROBLEMS THAT REQUIRE THEM TO BE PLACED IN A NURSING HOME FACILITY. IN SOME CASES THIS OCCURS BECAUSE THEY LACK THE ACCESS TO QUALITY HOME CARE SERVICES. THESE INDIVIDUALS ARE OFTEN DISCHARGED FROM THE HOSPITAL SETTINGS SICKER AND REQUIRE MORE MEDICATION, EQUIPMENT AND SERVICES THAN DO THE MAJORITY OF ELDERLY.

THE AFRICAN-AMERICAN ELDERLY OFTEN EXPERIENCE GREAT DIFFICULTY OBTAINING ACCESS TO A QUALITY NURSING HOME FACILITY DUE TO THEIR LIMITED INCOMES. ONCE THEY DO OBTAIN A BED IN A FACILITY, THE NURSING HOME IS OFTEN MANY MILES AWAY FROM RELATIVES, FRIENDS AND LOVED ONES. CONSEQUENTLY, INSTITUTIONALIZATION FOR THE AFRICAN-AMERICAN ELDERLY OFTEN FURTHER ISOLATES THEM FROM THEIR FAMILY MEMBERS. THE NMA'S QUALITY ASSURANCE TASK FORCE MADE A SERIES OF RECOMMENDATIONS, NAMELY:

(1) MEDICARE AND HOME HEALTH AGENCIES NEED TO UTILIZE INNOVATIVE APPROACHES TO PROVIDE QUALITY HOME HEALTH CARE TO THE ELDERLY AFRICAN-AMERICANS DIRECTLY, INCLUDING PAID ESCORTS, HAZARDOUS DUTY COMPENSATION TO STAFF, BOTH OF WHICH WOULD INCREASE AVAILABILITY OF HOMEBOUND SERVICES TO ELDERLY AFRICAN-AMERICANS IN POORER, CRIME-RIDDEN NEIGHBORHOODS.

(2) IMPROVE PATIENT EDUCATION TO AFRICAN-AMERICAN PATIENTS TO ASSURE BETTER UNDERSTANDING OF HOW TO OBTAIN HOME HEALTH MEDICAL SERVICES IN THE EXISTING FRAGMENTED HEALTH CARE DELIVERY SYSTEM.

(3) MEDICAID PROGRAMS MUST REDUCE BURDENSOME REQUIREMENTS THAT LIMIT THE PATIENT'S ACCESS TO VITAL MEDICATIONS ON A MONTHLY BASIS.

C. THERAPEUTIC SUBSTITUTION

IN THE AREA OF DRUG TREATMENT, QUALITY CARE SHOULD NOT BE SACRIFICED DUE TO BUDGETARY RESTRAINTS WHICH RESULT IN THE POOR AND ELDERLY RECEIVING THERAPEUTICALLY SUBSTITUTED DRUGS AS A MEANS TO REDUCE MEDICAID EXPENDITURES. IN JUNE OF THIS YEAR, THE OFFICE OF MANAGEMENT AND BUDGET PROPOSED TO THE BUDGET SUMMIT CONFEREES A PLAN TO INCLUDE CLASSIFYING DRUGS AND SELECTING THE LEAST EXPENSIVE DRUG IN EACH CLASS "AS THE PREFERRED DRUG." PHARMACISTS WOULD BE REQUIRED TO SUBSTITUTE THE PREFERRED DRUG IN ALL MEDICAID PRESCRIPTIONS WITHOUT THE KNOWLEDGE OF, OR CONSENT OF THE PATIENT'S PHYSICIAN. NMA RECOGNIZES THE INHERENT AND REAL DANGER IN UTILIZING COST ALONE TO SUBSTITUTE A MEDICATION PRESCRIBED BY A PHYSICIAN, WHO HAS PERSONALLY EXAMINED THE PATIENT AND WRITTEN THE PRESCRIPTION BASED UPON THE INDIVIDUAL PATIENT'S ENTIRE MEDICAL HISTORY AND HEALTH MILIEUX. DRUG ALLERGIES, HARMFUL SIDE EFFECTS,

LESSER EFFECTIVENESS IN DIFFERING POPULATIONS, OR EVEN DEATH MAY RESULT FROM SLIGHT VARIATIONS IN THE QUALITY AND STRENGTH OF MEDICATION. FURTHER, CHANGING A PRESCRIPTION WITHOUT THE KNOWLEDGE OF, OR CONSENT OF, THE PHYSICIAN IS NOT LEGAL IN MOST JURISDICTIONS.

DISPENSING MEDICATION TO MEDICAID RECIPIENTS BASED SOLELY ON PRICE CREATES ANOTHER OBJECTIONABLE DISTINCTION IN MEDICAL SERVICES PROVIDED TO THE POOR, MANY OF WHOM ARE AFRICAN-AMERICAN OR OTHER MINORITIES. THE OFFICE OF MANAGEMENT AND BUDGET PROPOSAL CLEARLY IMPLIED THAT THE ELDERLY, BLIND, DISABLED AND INDIGENT ARE ONLY WORTHY OF THE CHEAPEST MEDICATION REGARDLESS OF ITS EFFICACY, AND NOT THE PRESCRIPTION THAT BEST FULFILLS THEIR VITAL MEDICAL REQUIREMENTS. NMA IS OPPOSED TO THIS TREATMENT OF MEDICAID RECIPIENTS THAT IS CLEARLY DISCRIMINATORY AND "ASSIGNS A DIMINISHED VALUE OF LIFE" TO THIS GROUP OF DISADVANTAGED PATIENTS. A NEW LOW WOULD HAVE BEEN REACHED IF THIS NEW FORM OF DISPARATE TREATMENT IS PERMITTED.

V. <u>LONG TERM CARE FINANCING NEEDS FOR THE ELDERLY</u>

THE AVAILABILITY OF HEALTH CARE RESOURCES FOR THE CHRONICALLY ILL, MOST OF WHOM ARE OVER 65 YEARS OF AGE, REMAINS A MAJOR PUBLIC POLICY CONCERN. THIS IS PARTICULARLY TRUE BECAUSE MANY AFRICAN-AMERICAN ELDERLY HAVE A MISTAKEN IMPRESSION THAT THE EXPENSES OF CHRONIC ILLNESSES ARE COVERED BY THE EXISTING MEDICARE PROGRAM. MANY OTHERS BELIEVE THAT THEIR RETIREMENT PRIVATE HEALTH INSURANCE PLAN WILL ADEQUATELY COVER LONG-TERM CARE EXPENSES. THEY FAIL TO REALIZE THAT NEITHER MEDICARE NOR MOST PRIVATE HEALTH INSURANCE COVER ESSENTIAL LONG-TERM HEALTH CARE SERVICES.

THE NMA'S BOARD OF TRUSTEES RECOGNIZED THIS PROBLEM AND IN 1988 ESTABLISHED A LONG-TERM HEALTH CARE TASK FORCE. THE TASK FORCE MADE A SERIES OF RECOMMENDATIONS, WHICH ARE AS FOLLOWS:

1. MEDICARE MUST ESTABLISH A "PART C", TO FINANCE THE LONG-TERM CARE NEEDS OF MEDICARE BENEFICIARIES WHO REQUIRE LENGTHY INSTITUTIONALIZATION IN A NURSING HOME FACILITY.
2. MEDICARE AND MEDICAID PROGRAMS MUST EXPAND THEIR EARLY DETECTION AND PREVENTIVE MEDICINE PROGRAMS. THIS MUST BE ACHIEVED BY FINANCING MAMMOGRAPHY SCREENING, HIGH BLOOD PRESSURE CHECK-UPS, AND GREATER EFFORTS TO EDUCATE THE ELDERLY ABOUT THE IMPORTANCE OF PREVENTIVE HEALTH CARE.

3. MEDICAL SCHOOLS AND COLLEGES OF ALLIED HEALTH SCIENCES MUST EXPAND THEIR TRAINING PROGRAMS TO INCLUDE GERONTOLOGY MEDICINE TO UNDERSTAND THE HEALTH CARE NEEDS OF LONG-TERM PATIENTS.
4. MEDICARE AND MEDICAID PROGRAMS SHOULD REQUIRE MORE FREQUENT PHYSICIAN VISITS TO NURSING HOME PATIENTS AS A REQUIREMENT OF THE TREATMENT PLAN.

VI. OVERALL RECOMMENDATIONS

AN INCREASE IN FEDERAL FUNDING AND FEDERAL PROGRAMS IS NEITHER SUFFICIENT TO ALLEVIATE THE PROBLEMS FACED BY THE ELDERLY IN TERMS OF ADEQUATE HEALTH CARE AND THE COSTS ASSOCIATED WITH IT, NOR IS IT A PRUDENT RECOMMENDATION IN THE CURRENT CLIMATE WHICH DEMAND BUDGET RESTRAINT. THE CONGRESS MUST DETERMINE WHICH PROGRAMS WORK AND THOSE MUST BE STRENGTHENED. IT MUST LIKEWISE ELIMINATE THOSE PROGRAMS THAT DO NOT. FUNDS MUST BE SHIFTED FROM INEFFECTIVE AND UNNECESSARY PROGRAMS TO THOSE THAT ARE MOST ESSENTIAL. WITH THE FASTEST GROWING SEGMENT OF THE AMERICAN POPULATION BEING THAT OF MINORITIES, THE HEALTH OF OUR NATION IS INEXTRICABLY INTERTWINED WITH THE HEALTH OF AFRICAN-AMERICAN AND OTHER MINORITY POPULATIONS IN THIS COUNTRY.

COMMUNITY-BASED PROGRAMS REPRESENT ONE SUCH EFFECTIVE AND ESSENTIAL PROGRAM. IT IS IMPORTANT TO ESTABLISH COMMUNITY BASED PROGRAMS WHICH MONITOR AND EDUCATE THE ELDERLY IN WAYS TO MAINTAIN GOOD HEALTH. FOR EXAMPLE, RECOGNIZING THE PREVALENCE OF HIGH BLOOD PRESSURE AMONG AFRICAN-AMERICANS. A RHODE ISLAND AFFILIATE OF THE AMERICAN HEART ASSOCIATION ESTABLISHED A PROGRAM WHEREBY MEMBERS MET WITH CHURCH LEADERS OF THE BLACK CHURCH ALLIANCE TO INTRODUCE THE IDEA OF AN ONGOING SCREENING PROGRAM TO REACH THE BLACK COMMUNITY THROUGH CHURCHES.

THE 1988 SURGEON GENERAL'S WORKSHOP ON HEALTH PROMOTION AND AGING EMPHASIZED GOOD NUTRITION AS AN ESSENTIAL ELEMENT TO A HIGH QUALITY OF LIFE FOR THE ELDERLY. THE WORKSHOP REPORT IDENTIFIED PRIORITIES RELATED TO:

(1) SOUND PUBLIC EDUCATION TAILORED TO THE SPECIAL CONCERNS OF OLD AGE, SUCH AS MULTIPLE DRUG REGIMENS, APPROPRIATE ENERGY INTAKES, AND THE EFFECTS OF EXISTING CHRONIC DISEASES ON NUTRITIONAL STATUS;
(2) PROFESSIONAL EDUCATION ON GERIATRIC CONCERNS INTEGRATED INTO THE CORE CURRICULUM, INSERVICE

TRAINING, AND CONTINUING EDUCATION OF DIETITIANS AND OTHER HEALTH CARE PROFESSIONALS;

(3) CREDENTIALED NUTRITION PROFESSIONAL COUNSELING IN INSTITUTIONAL OR COMMUNITY-BASED PROGRAMS TO PROVIDE HEALTH SERVICES TO THE ELDERLY; AND

(4) PROVISION OF ESSENTIAL FINANCING OF NUTRITION SERVICES FOR THE ELDERLY AS PART OF ROUTINE AND LONG-TERM CARE.

EDUCATION, COMMUNITY SUPPORT, AND EFFECTIVE AND ESSENTIAL FEDERAL ASSISTANCE ARE NECESSARY TO ENSURE THAT THE HEALTH CARE NEEDS OF THE ELDERLY POPULATION, IN GENERAL, AND THE ADDITIONAL REQUIREMENTS OF THE AFRICAN-AMERICAN ELDERLY, IN PARTICULAR, ARE MET.

## VII. CONCLUSION

MESSRS. CHAIRMEN, IT IS IMPERATIVE THAT THE PRESIDENT OF THE NMA BRING TO YOUR ATTENTION A VERY SERIOUS BREACH IN OUR HEALTH CARE DELIVERY SYSTEM WHICH WILL IMPACT THE ELDERLY AND ALL OTHER AMERICANS SERVED NEGATIVELY. WE ARE BEGINNING TO LOSE PHYSICIANS OUT OF THE PRACTICE OF MEDICINE AT AN ALARMING RATE IN GHETTOS AND UNDERSERVED AREAS BOTH RURAL AND URBAN, PRIMARILY BECAUSE OF INADEQUATE REIMBURSEMENT. THE NMA IS CURRENTLY IN THE PROCESS OF DEFINING ON A NATIONAL BASIS THE EXTENT AND CAUSES OF A LOSS OF PHYSICIAN PRACTICES. ONCE WE HAVE THIS DATA IN HAND, WE WILL MOST LIKELY HAVE TO COME BEFORE THE APPROPRIATE CONGRESSIONAL COMMITTEES TO SEEK LEGISLATION FOR CORRECTING THE LOSS OF SO VALUABLE A HUMAN RESOURCE, PHYSICIANS, AND ESPECIALLY THOSE WHO SERVE IN GHETTO AND UNDERSERVED AREAS. FINALLY, LET ME EMPHASIZE THAT NMA STANDS READY TO ASSIST THE CONGRESS IN STRUCTURING EFFECTIVE PROGRAMS THAT LEAD TO AN IMPROVED HEALTH CARE DELIVERY SYSTEM FOR ALL AMERICANS, BUT ESPECIALLY FOR ELDERLY.

Mr. STOKES. Thank you very much, Dr. Johnson.

We will now move to Dr. Hazel Harper, representing the National Dental Association.

Dr. Harper.

**STATEMENT OF HAZEL HARPER, PRESIDENT, ROBERT T. FREEMAN DENTAL SOCIETY, REPRESENTING THE NATIONAL DENTAL ASSOCIATION, WASHINGTON, DC**

Ms. HARPER. Good morning, Chairman Stokes. Thank you for providing the National Dental Association with the opportunity to testify before you.

Since the 1980's with the emergence of the Gray Panthers, the public perception of adults age 65 and older has changed. Sterotyping the elderly is more difficult these days because medical advances have improved the overall health status of seniors over the last decade. We now have the new old and the old old.

People today who are called the new old are between the ages of 65 and 74. They grew up with a more preventative focus and have greater expectations. Therefore, their oral conditions are different from those of people age 75 to 84. By the year 2000, nearly 20 percent of Americans will be age 55 or older. The number of adults 85 and older, the fastest growing group, expected to increase by 110 percent.

Each cohort of persons to reach the milestone age of 65 does so with more of their natural teeth. The emphasis of preventative dentistry has increased a population of older adults who understand that losing teeth is not a normal part of the aging process. In 1960, almost 60 percent of older persons were completely edentulous. Today, that number has dropped to below 40 percent, and now, over 60 percent of persons age 65 and older still have their natural teeth.

Although longer retention of natural teeth enhances the quality of life, maintaining a natural dentation imposes additional burdens of responsibility on the geriatric patient as well as the dental care provider. The longer people maintain their natural teeth, the greater the risk for developing cavities and gum disease.

Currently the National Dental Association represents approximately 7,000 black dentists who treat the 27 million black citizens of this country, including a number of nearly 3 million persons over 55 years old. Demographically, about 50 percent of our geriatric population lives in only eight States: California, New York, Florida, Pennsylvania, Texas, Illinois, Ohio, and Michigan. Dentists in these States will have to accept greater responsibility for servicing the needs of this population group.

In dentistry, a very strong emphasis is placed on the physical evaluation of the geriatric patient. Physical evaluation in dentistry consists of the recognition of the disease in the medically compromised patient, the assessment of the physical status or condition of the patient, and providing special management for the safety and comfort of the patient during dental treatment.

Consulation with the patient's physician is vital in the treatment of severely medically compromised patients and a health care team approach is essential in the management of older patients with

chronic diseases. Most older persons have at least one chronic condition and many have multiple conditions. The most frequently occurring conditions for the elderly are arthritis, hypertension, hearing impairments, heart disease, orthopedic impairments, diabetes, sinusitis, and visal impairments. Each of these areas pose specific concerns and management considerations for the dental care providers.

Arthritis cannot only affect the ability of the patient to hold and use a toothbrush, but severe and generalized arthritis can render the patient nonambulatory on certain days, thus making dental office visits impossible. In addition, arthritis of the jaw joints limits the ability to open the mouth or to masticate comfortably. Arthritis patients are frequently on daily does of aspirin, which also restricts performing of oral surgery procedures due to impaired blood clotting mechanisms.

Most hypertension medications cause xerophstomia, or dry mouth. Decreased salivary flow adversely affects the health of the teeth and gingiva causing an increase in the occurrence of tooth decay and gum disease. As a matter of fact, older persons in the United States are at greater risk for developing cavities than 14-year-olds. Root caries affect up to 70 percent of older people who have natural teeth.

In addition to hypertension medications, there are also over 250 drugs that have the potential to cause dry mouth as a side effect. These include certain types of antihistamines, diuretics, and tranquilizers. Radiation treatments also result in xerophstomia, and xerophstomia is uncomfortable.

Decreased salivary flow makes eating, swallowing, and even speaking difficult. Unless the patient is particularly diligent about oral hygiene, prolonged xerophstomia can result in potential tooth loss due to the increased accumulation of plaque around the teeth.

Since diabetes represents a decreased ability of the body to defend itself against infection, lowered host resistance contributes to oral infections. Periodontal disease in diabetic patients is very difficult to control. Elevated blood sugar levels promote fungal infections which adversely affect the entire body. Dental care is significantly important in diagnosing and treating oral infections so that diabetes can be controlled.

In stroke victims, loss of speech, memory, and muscle paralysis may occur which affect all routine duties including brushing and flossing. When the dominant hand is affected, tooth brushing must be relearned with the previously little used hand. If the stroke affects nerves on the side of the face, resulting paraseizure may cause the patient to bite their cheek or tongue without feeling it. They may not be able to detect ulcers caused by dentures on that side of their mouth.

In addition, the management of stroke victims in the dental office is compromised because of the patients' ability to open their mouths wide enough for proper instrumentation. Frequently, mouth props must be wedged in place in order to allow for access, and patients are unable to hold their heads in proper position so that dentists learn to render care to patients whose faces can only turn to one side.

On the national level, the National Dental Association is doing many things to try to address these problems. The NDA hosts annual scientific conventions which include continuing education courses for the treatment and management of the geriatric patient. In addition, research articles and manuscripts addressing the special needs of this groups are published in the "Journal of the National Dental Association."

Our organization is committed to increasing the access to dental care for the elderly by the elimination of financial barriers to care. We advocate increased funding levels for dental care through Medicare and Medicaid. In addition, continued dental coverage for retired workers has been encouraged to further reduce financial barriers.

Presently, out of 30 million persons over 65 years old, only 6 percent have dental insurance. In our organization, dentists across the country provide senior citizens' discounts. We, additionally, are sensitive to the special needs of elderly patients and schedule early morning appointments to eliminate appointment delays and schedule short rather than extended appointments, so that the length of time in the dental chair is kept to a minimum. Dental offices are designed to accommodate wheelchair patients and x-ray machines can also be adjusted for the nonambulatory.

Local chapters have volunteer programs where dentists provide services to nursing homes and also fabricate dentures at laboratory costs. Special financial arrangements are made for senior citizens on fixed incomes.

Finally, the National Dental Association through the NDA Foundation, has been able to solicit the support of major corporations, such as Colgate-Palmolive and Proctor and Gamble, in obtaining funding for scholarships and for special project support. These corporations also engage in collaborative efforts to promote dental recruitment and fund science health fairs in target cities. These efforts will serve to increase the number of black dental providers who are desperately needed to service the needs of the rapidly increasing geriatric populations.

In summary, the recommendations of the National Dental Association in addressing the problem of the specific needs of the elderly include the establishment of well-defined career tracks for geriatric dental academicians who will then be responsible for undergraduate and postgraduate educational programs, research, and patient care for the elderly. Funding must be made available to support students of geriatric dentistry.

The CHAIRMAN [resuming Chair]. Dr. Harper, I hate to do this, but let's put the remainder of your statement in the record. Were you just about through?

Ms. HARPER. Yes, I was, sir.

The CHAIRMAN. Go ahead and finish your statement. I do apologize for interrupting, but we must continue.

Ms. HARPER. We would also like to make a final recommendation to solicit increased financial support from the major corporations, such as dental product manufacturers and pharmaceutical companies. We need their help, and our elderly deserve their support.

Thank you for inviting the National Dental Association to testify at your hearing today.

The CHAIRMAN. Thank you, Dr. Harper. We appreciate your being here this morning.

We now have Alicia Georges, president of the National Black Nurses' Association.

## STATEMENT OF C. ALICIA GEORGES, PRESIDENT, NATIONAL BLACK NURSES' ASSOCIATION, NEW YORK, NY

Ms. GEORGES. Mr. Chairman, Congressman Stokes, members of the Senate Special Committee on Aging, the National Black Nurses' Association representing black registered nurses, licensed and vocational nurses, and student nurses in its 50 chapters in the territories of the United States thanks you for inviting us to share some of our concerns and recommendations for meeting the health care needs of a special group in our country, the black elderly.

We are concerned about the plight of the black elderly person, whether they reside in our large cities, the suburbs, the rural parts of our country, or in the territories of the United States. Our members work in long-term care facilities, acute care facilities, ambulatory care units, community-based health care facilities, health departments, and home health agencies. We have identified that the problems we have seen with the black elderly are multifactorial in nature, but have some common threads regardless of geographics.

These are the following: access to primary health care facilities that can provide a range of services, managing of the activities of daily living, which inevitably lead to poor nutritional intake and subsequent exacerbation of their chronic health problem, social isolation, be it self-imposed because of fear of becoming a crime victim or because of lack or transportation or functional disabilities, and lack of coordination of needed home health and social services.

Black elderly patients may become what is referred to as disposition problems because they cannot return to their homes because of a lack of services necessary to maintain them in the community. Because there is a probable waiting list, these persons must remain in an acute care hospital until suitable arrangements can be made for their long-term care. The question then constantly arises: Could this have been avoided? The answer is yes.

The report, Healthy People 2000, addresses the fact that many of our elderly in this country could best be served if we prevent the ill from being disabled and help people with disabilities to maintain a certain level of functioning. The issue of nutrition becomes an important factor in the maintenance and restoration of health for the elderly person.

Another issue that requires our mention to you today is the lack of nursing staff in long-term care facilities. This shortage of staff, professional nursing staff and ancillary staff, compounds the problem of care for the black elderly who must remain in skilled nursing facilities, extended care facilities, or health-related facilities. We would like to offer some suggestions for the possible amelioration of the problems identified.

First and foremost, we must work vigorously to extend the lives of the black elderly persons in our society. It is not sufficient for us to quote the life expectancy for blacks as 69.4 or 69.6 years. The shortened lifespan denies this country and its citizens some of its

valuable resources: people. We would like recommendations made by the Healthy People 2000 report to be implemented and/or included in health care delivery models.

To accomplish this, we must have more primary care clinics or services available in the community for the black elderly. This includes persons who also reside in rural parts of America.

Geriatric clinics are nothing new, but they are not sufficient in number for the persons that they need to serve. If and when established, they must provide a range of services, that also include home visiting and the provision of home health services and/or other supportive services needed by the black elderly that would enhance the quality of life.

The one-stop approach to health care services being suggested by HHS for maternal/child health services could be evaluated for possible replication. These clinics must also pay attention to health promotion activities. Physical activity is an important ingredient in the life of the elderly. Paying attention to this aspect and encouraging this may be an important aspect of care giving.

Initiatives must be developed to encourage nursing research in the care of the black elderly. An initiative such as the recent RFP of the Division of Nursing, the Agency for Health Policy and Research, and the National Center for Nursing Research for rural health care nursing models for minorities should be examined for use with the black elderly. The problems of social isolation, which in turn may lead to depression and suicide, need to be studied in relationship to the black elderly.

Further funding or programs that prepare nurses skilled in caring for the elderly with some emphasis on the black elderly must occur. The teaching nursing home grants awarded a few years ago should offer us some ideas. This might again be instituted with emphasis on those institutions with a high black elderly clientele. It would also encourage nurses to participate in this type of employment.

The National Black Nurses' Association continues to provide services to the black elderly in this country through our programs of service implemented by our chapters. Since black Americans continue to be disproportionately affected by cancer, diabetes, hypertension, stroke, and cardiovascular diseases, our secondary prevention efforts continue. This includes taking blood pressures at senior citizen centers and referring to appropriate medical care, teaching about the effects and side effects of medications, encouraging our older black females to have a breast exam, nutrition counseling, and also encouraging physical activities by forming and leading exercise classes for those permitted to participate by their physicians. We also encourage our members to work in long-term care facilities and to seek graduate degrees in care of the older adult.

Lastly, there must be a committed commitment by this country's Health Care Financing Administration for the continuance of Medicare and Medicaid benefits with a reevaluation of Part B to provide greater home health services and continuance of Medicaid benefits without restrictions to health, medical care, nursing care, and access to medications.

The care of the black elderly must be a priority for all health care providers. Thank you.

The CHAIRMAN. Thank you very much, Ms. Georges. [Applause.]

I tell you what—you win the award. You were right on the nose with this 5-minute rule. Thank you so much.

By the way, we have to have any limitations, but we are very fearful that Congressman Stokes, Senator Heinz, and I may have votes on the floor of the House and the Senate. We would hate to have to leave all of you stranded here while we do that, so that is why we are sort of hurrying along.

Dr. Hill.

## STATEMENT OF WENDELL T. HILL, JR., PRESIDENT, NATIONAL PHARMACEUTICAL ASSOCIATION

Mr. HILL. Good morning, Chairman Pryor, Senator Heinz, and Chairman Stokes. I wish to thank you for the courtesy that has been extended to the National Pharmaceutical Association in giving us an opportunity to express our views on the subject of drug use and the elderly.

As a group, elderly patients have more illnesses and take more medications than do younger patients. Medication errors and lack of comprehension of treatment plans are prevalent among the elderly patients. These factors contribute to the widespread incidence of adverse drug reactions in the elderly.

Age differences in pharmacokinetics may contribute to an increased sensitivity of older patients to both the therapeutics and the toxic effects of drugs. The aged are more sensitive to both the therapeutic and the toxic effects of drugs.

Pharmacists must have an increased familiarity with the differences in the physiology and the pharmacology associated with aging in order to be better prepared to widely advise other professionals, patients, and caregivers about the responses of drugs in the elderly. The proportion of elderly in the population has been rising steadily for the past several decades.

Sudden changes in intellectual function can result from medication in misuse. Many patients have difficulty when taking the medication as prescribed. The rate of misuse has been found to be as high as 50 percent of all outpatients. One study showed that 59 percent of elderly outpatients made one or more medication errors and that 26 percent of those errors were quite serious.

Persons over 65 will make up almost 17 percent of the population by the year 2020. In 1986, they made up about 11 percent. Older people consume about 25 percent of all prescription drugs, yet by the year 2020, they will consume about 40 percent of all prescription drugs.

People under 65 use an average of 3.4 prescription drugs regularly. For those over 65, the number increases to 9.7 drugs which are used regularly every day. Many people fail to follow instructions when taking such a complex array of prescriptions and experience adverse reactions.

The incidence of side effects to common drugs is three times greater for people between 70 and 79 than for people 40 to 49. Ninety-five percent of people over 65 are not in institutions. There-

fore, their drug use is highly unsupervised at a time when they need support in order to maintain compliance.

Older persons commonly see three or more physicians and two or more pharmacists regularly. In such instances, these caretakers frequently do not talk to each other about the patient's medical or prescription needs. Agencies devoted to servicing noninstitutionalized elderly have many opportunities for educating older persons about drug use, to monitor compliance and other behaviors, and to intervene when appropriate.

Using California hospital data, one finds that the senior population is the prime target of medications that harm rather than heal. Hospital discharge records reveal that 62 percent of reported adverse reactions are associated with legally administered drugs. At the top of the list of high risk drugs for people over 60 are those medications which affect the cardiovascular system.

I would like to enumerate some of the problems. Elderly poor and black often lack the money necessary to seek qualified advice. They self-diagnose their problems and think of them as minor. The most frequent therapeutic error is omission of the medication prescribed. Drugs that make us forget our pressures and relieve stress can make us feel safe while engaged in risky activities. It has been known that patients on psychotherapeutic drugs have been known to fall and have fractured hips.

A University of Washington study found that pharmacist consultations reduce medication consumption, lower drug costs, and decrease adverse reactions among the elderly. There is a great need for studies to define the scope and extent of the problems related to drug use among the black elderly.

[The prepared statement of Mr. Hill follows:]

Testimony of
Wendell T. Hill, Jr., Pharm.D.
President, National Pharmaceutical Association

Before the

U.S. SENATE SPECIAL COMMITTEE ON AGING
CONGRESSIONAL BLACK CAUCUS HEALTH BRAIN TRUST
"PROFILES IN AGING AMERICA:
MEETING THE HEALTH CARE NEEDS OF THE NATIONS BLACK ELDERLY"

# DRUG MISUSE AMONG OLDER PEOPLE

Senators, I wish to thank you for your courtesy in offering THE NATIONAL PHARMACEUTICAL ASSOCIATION an opportunity to express views on the subject of "Drugs Use and the Elderly."

As a group, elderly patients have more illness and take more medications that younger patients. Medication errors and lack of comprehension of treatment plans are prevalent. These factors contribute to the widespread incidence of adverse drug reactions in the elderly.

Age differences in pharmacokinetics may contribute to an increased sensitivity of older persons to both the therapeutic and toxic effects of drugs. The aged are more sensitive to both the therapeutic and the toxic effects of many drugs.

Pharmacists must be familiar with the differences in physiology and pharmacology associated with aging in order to be better prepared to wisely advise other professionals and patients about the responses to drugs in elderly people.

The proportion of elderly in the population has been rising steadily over the past several decades.

Sudden changes in intellectual function can result from medication misuse. Many patients have difficulty taking medication as prescribed. The rate has been found to be as high as 50% of all outpatients. One study showed that 59% of elderly outpatients made one or more medication errors and 26% serious errors.

Persons over 65 will make up almost 17% of population by 2020. In 1986, 27 million persons over 65 -- 11.5% of population.

Older people consume 25% of all prescription drugs; by the year 2020 the number will become 40%.

People under 65 use an average of 3.4 prescription drugs regularly. For over 65 the number is 9.7 drugs used regularly.

Many people fail to follow instructions when taking drugs and experience adverse reactions.

Older people experience more adverse drug reactions than do members of the general population.

People over 75 years are seven times more likely than a 25 year old to have an adverse reaction to a drug.

The incidence of side effects to common drugs is three times greater for people between 70 and 79 than for people 40 to 49. 95% of persons over 65 are not in institutions, therefore their drug use is probably unsupervised at a time when many need support to assure proper compliance with instructions.

Older persons commonly see three or more physicians and two or more pharmacists regularly. And in most instances, none of these caretakers are talking to each other about the needs of the patient.

Agencies devoted to servicing non-institutionalized elderly have many opportunities for educating older persons about drug use and to monitor compliance and other behaviors, and to intervene when appropriate.

Using California hospital data, one finds that senior population is the prime target of medications that may harm rather than heal. Hospital discharge records reveal that 62% of reported adverse reactions are associated with legally administered drugs.

At the top of the list of high risk drugs for people aged 60 and over in California are those medications which affect the cardiovascular system. In 1986, 6,588 adverse reactions involving cardiotonic glycosides and cardiac rhythm regulators were used by senior citizens.

On April 25, 1989, the Food and Drug Administration announced that two drugs, Tambocor and Enkaid, widely used to treat heartbeat irregularities were linked with an abnormally high rate of death.

A report based upon California hospital discharge records indicated that 62% of reported adverse drug reactions associated with legally administered drug therapies involved patients 60 years of age and older. Total hospitalization charges for the 31,326 senior patients identified in the report were $288,993,771.

Nationally, an estimated 243,000 older Americans were hospitalized by an adverse drug reaction in 1985, according to a January 1989 report by the Inspector General for the Department of Health and Human Services. Officials of the department admit the estimate may be low.

Medication problems of senior citizens extend well beyond adverse drug reactions. Elderly people typically cannot manage their medication regimen without help. They forget to take the medication, they use outdated drugs which probably have reduced potency, they skip dosages when they (elderly patients) believe they do not need them. Researchers claim that 40 to 70% of elderly make medication compliance errors. These oversights can accelerate the need for hospitalization. Probably the members of this Committee panel have observed these problems among close family members or associates who are otherwise talented and accomplished persons.

Seniors, people over 65, comprise 12% of the population, and use over 30% of the prescription drugs and 40% of the non-prescriptions drugs dispensed.

In 1977, the National Center for Health Services Research conducted a survey which revealed that the elderly averaged 14.2 prescriptions per year compared to a general population average of 7.5.

In 1986, the Public Citizens Health Research Group found the prescription rate to be 15.5 drugs per year based upon retail sales of 613 million prescriptions per year to seniors.

The large number of drugs taken increases the risk for adverse reactions by mixing drugs.

**PROBLEMS**

I will now list for you some of the specific problems which require corrective action.

Elderly and poor Blacks often lack the money necessary to seek qualified advice. They self diagnose their problems and think of them as minor.

The most frequent therapeutic error is omission.

Drugs that make us forget our pressures and relieve stress can make us feel safe while engaging in risky behavior.

Label discrepancy (dosage instructions confusing or incorrect) 37%

Underused medications 24%

Patient cannot read the label 14%

Patient cannot open child proof container 12%

Patient does not understand purpose of medication 7%

Patient shares drugs with others 7%

Poor storage, drugs lose potency 6%

Outdated drugs lose potency 6%

Multiple prescriptions for same condition from multiple physicians. 4%

Overuse of medications 4%

Patient is poor or near poor and cannot afford to purchase the prescribed drugs.

Non-compliance with instructions, rates for the senior population range from 40% in one study to 75% in another. Noncompliance may account for 15% of geriatric hospitalizations of people age 70 and over.

The FDA approves new drug applications based on clinical studies involving healthy, young adults. Only 17 of the 200 most commonly used prescribed drugs give geriatric dosage instructions according to the Inspector General for the Department of Health and Human Services.

Of the 24 most commonly prescribed drugs for the elderly, only three product labels mention geriatric adverse reactions and only five include geriatrics under dosage and administration.

Adverse drug reactions may occur shortly after therapy is initiated, or it may take years before the reaction can be detected. Some adverse reactions, or side effects are predictable, some are allergic or hypersensitive in nature, all these reactions can be toxic.

Pharmacists should play a key role in controlling potential medication misuse among elderly. They must maintain records of the patient drug regimen, they have a duty to detect drug use which could cause an adverse reaction with other prescribed medications. They must explain the proper use of the drug. They should be required to provide a proper environment suitable for carefully and patiently communicating with patients and assuring that the patient comprehends the instructions. Pharmacists recognize this need and want to provide this service and consumers want the service. Unfortunately, the current system does not compensate the pharmacist for this important service in the ambulatory setting.

Patients are better served in this regard in nursing homes where the consultant services are mandated and the pharmacist is compensated for this valuable activity.

A University of Washington study found that pharmacist consultations reduce medicine consumption, lower drug costs and decrease adverse reactions among the elderly. The study involved 183 elderly, low-income apartment residents with a mean age of 77.

There is a great need for more studies to define the scope and extent of problems related to the use of medications among Black elderly. There is absence of data to document the severity and extent of such problems, e.g. accidental overdosing, bodily injury due to falls triggered by adverse reactions, vision and dietary problems related to adverse reactions, and most of all problems of personal competence and mental confusion related to adverse drug reactions.

Adverse drug reactions often contribute to an injury. For example, a drug reaction could cause an elderly person to lose balance, fall and fracture a hip. The principal diagnosis is a fractured hip. The adverse drug reaction is not reported as a cause of injury. Users of anti-psychotic drugs are twice as likely to fracture a hip as non-users and almost 14% of all hip fractures in this country are linked to falls produced by side effects of psychotropic drugs.

There are insufficient data describing the number of elderly persons who are hospitalized due to medication misuse which did not manifest itself as an adverse drug reaction. For example, the elderly black patient who neglected to take prescribed medications and who subsequently suffered a health setback linked to lack of medication due to lack of support care.

Recommendations:

Congress should support efforts to identify medication misuse patterns among the elderly. Identify patients with adverse drug reactions by age, location, type of drug involved and method of payment for treatment. This information may help educators and professional associations to pinpoint medication problem areas.

Congress should support drug review intervention programs and determine the cost effectiveness of education physicians who prescribe and pharmacists who dispense medications that do not meet a predetermined drug therapy formula.

Congress should support requiring the pharmacist to serve as medication managers for elderly. Have the pharmacist thoroughly explain the use of a prescribed drugs at the point of sale.

Congress should support programs for increasing the caretakers' knowledge of drugs used in treating geriatric patients. Caretakers include a wide variety or persons.

Congress should support programs to facilitate communication between professionals who prescribe and professionals who dispense to share experience and expertise in the use of drugs in the elderly. Local, state and national workshops held jointly by professional associations at least annually would ideally serve this function. One subject for sharing would be the development of a cost-benefit tracking system. Explore ways to expand the resources of medication education programs. The inability or reluctance of program administrators to establish cost benefit measurements can be attributed in part to the lack of an established funding base.

Congress should support a national clearinghouse of brochures, videos and program concepts.

The CHAIRMAN. Dr. Hill, we are going to put your entire statement into the record. I am very impressed with those statistics that you have given. In fact, some of those, I have not seen.

For example, the average elderly citizen over age 65 in our country takes about 9.7 different prescription drugs each day?

Mr. HILL. Yes, sir.

The CHAIRMAN. I want to do something, and I hope I don't rain on the parade this morning.

I was out of the room on the phone awhile ago and I think that Dr. Johnson made mention of legislation that we have been discussing in recent weeks in the Senate and the House on some way to save costs in the Medicaid program for prescription drugs. I do not think that Dr. Johnson mentioned me by name—you did mention OMB—but let me plead a little bit guilty here.

The reason that OMB is looking at some cost savings in the Medicaid drug problem is because of some legislation that I introduced some months ago. So, we will just kind of put things on the table and talk openly and frankly.

First, I take strong exception to some organizations who maintain that even this approach will result in creating a second class system for the black elderly or the minority elderly. I want you to know that the purpose of the legislation that I introduced was to do one thing. That was to get a better price from the drug manufacturers. The purpose was not to substitute in therapeutic substitution drugs that are not as good as other drugs. That is not the purpose of my legislation.

What we are faced with today is a simple fact of life. That fact of life is that the very poorest of the poor in the United States of America today are paying the highest prices for their drugs. The pharmaceutical manufacturers are ripping us off.

I saw an article, Congressman Stokes, just 2 weeks ago in "Fortune" magazine that advised their investors who might want to invest in a high return stock. What is it? Drug stocks. Why? Because drug stocks are recession-proof. It says that the drug companies are going to continue, no matter if everybody else goes bankrupt in the country. The drug companies are going to enjoy 20 percent profit margins from now to eternity.

My legislation is designed to bring those people into line. The Medicaid program for the poorest of the poor is having to pay the very highest prices, 40 to 60 percent more for the same prescription drugs as we are paying for prescription drugs in our VA hospitals, our HMO's, and our hospitals.

We are going to have some testimony by one of our distinguished citizens of Arkansas, John Eason, who I have known for 20 years. He is going to tell how it is facing every day those folks where, in our State, we limit in the Medicaid program to six drugs. After that you are on your own. If that black elderly person 65 or over is having 9.7 different drugs, then they have to decide. They have to make a decision: What drugs am I not going to take?

What I am saying is: We are going to negotiate a better price for the poorest of the poor with these highly profitable drug manufacturers who have abused this system. That is what it's about.

I just wanted to talk about that a minute because that is close to my heart. I have seen some letters lately and some statements that

might sort of imply that this is some sort of way to have a less-efficient and less-effective drug program for the poor in our minorities. That is not the purpose of it, and I wanted to have that chance to respond.

Any comments that you have, I would be glad to receive. I must say that I have been rather frustrated in our lack of ability to communicate on the issue.

Dr. JOHNSON. I appreciate your comments, Senator. The thing that the National Medical Association was mostly concerned about—I am from North Carolina, and many of our doctors are in the South, as you must be aware—but we know that the payment for a doctor's visit is many times much less, Senator Pryor, than the cost of all the medications that the patient will be using from one day to the next, as already told you by Dr. Hill.

Many times, it gets to be a concern of the patient. Do they decide to pay the doctor? Do they decide to buy medicine? Or do they decide to forget both and pay for food, shelter, and lights?

So, one of the things you will notice that our presentation is saying to you is that we clearly understand that as a very serious problem. It has been. The question was: how to solve it?

We physicians did not wish to have someone else, after we had seen the patient, turn around and tell the patient to take something totally different when we don't even know they have changed. On top of that, that person was being given immunity from being prosecuted for adverse effects that happen to the patient. Therefore, our very strong opposition had nothing to do with reducing the cost of drugs to the poor.

I want to make sure we go on record for saying that, but we did not want to lose control of the patient to someone who really knew very little about them. They sometimes do not have the full history and changing drugs can create problems that the patient ought not to have.

The CHAIRMAN. Let me just state that I have introduced two pieces of legislation. In both of those pieces of legislation, the thrust of that legislation in each case is that the doctor retains control of the drugs that patient is going to take. I wanted to make certain that that was well understood.

I value that principle and I know that you as a physician value that principle. In no way was I trying to amend that principle nor erode it. I just hope we can get that out on the table. Please know that that is not the purpose of the legislation.

Dr. Hill.

Mr. HILL. Senator, I wish that the pharmaceutical end of health care would rise above 10 percent, but I believe it is around 10 percent or less of the total. Of the total health care dollar, about 10 percent goes to pharmaceuticals.

A solution to the problem of providing lower cost medications to patients is communication between the physician and the pharmacist who is filling the prescription. This has been done in some communities in a formal way by developing a formal panel in a given community such as occurs in HMO's so that everyone is in agreement with respect to how the drugs are to be used in that community among those folks that are using those prescriptions.

I would agree with Dr. Johnson that to change prescription medication without any communication with the prescriber is not a safe practice.

The CHAIRMAN. I can tell you that we are not going that way. The doctor is going to retain control.

Ms. Georges.

Ms. GEORGES. Senator Pryor, the National Black Nurses' Association—you all know that nurses are the largest number of health care providers. We are the ones who do the continued teaching and medication counseling. Our concern, again, as Dr. Hill clearly stated, is the 9.7 drugs that an elderly person takes. The restriction on numbers then becomes problematic. When we are talking about people who are disproportionately represented in morbidity and mortality statistics in regard to certain diseases, we think our concerns need to be clear and heard.

There must be a creative and innovative way of reducing costs of health care in this country. We support that. We are concerned that the most vulnerable might end up being the ones who will be adversely affected.

The CHAIRMAN. I appreciate that concern.

Dr. Hill, you are a pharmacist. I just want to take your statement one step further. You state that one way to help control the cost is for the pharmacist and the prescribing physician to get together and work out what is good.

Now, I would like to say that Dr. Hill, in the profession that he represents, the pharmacists, is one of those people who are standing behind that counter every day and who this morning are having to look their clients in the eye and say: We're sorry, but your drugs have gone up again this month.

You know, drug prices have increased 152 percent in 10 years. I do not blame the pharmacists. The pharmacist has no control over those prices. The pharmacist is caught in the middle.

Dr. Johnson is likewise not at fault. Who is at fault? I will just say it again. It is the greed of the pharmaceutical manufacturers. Then you have no option but to pass these costs on either to the program or to the patient.

This is what we are trying to attack right here. I certainly don't blame you; nor do I blame Dr. Johnson.

Dr. Harper.

Ms. HARPER. Senator Pryor, I would just like to say that the National Dental Association agrees, of course, with the concept of trying to reduce the cost of pharmaceutical and prescribed drugs for our patients. In addition to that, we have taken it a step further because we feel that it is the responsibility of the pharmaceutical companies to give back something to the geriatric population.

Many of the physicians, dentists, and pharmacies themselves offer senior citizen discounts to our patients. We would like to see the pharmaceutical companies be more responsive to the needs of our patients by also providing some support funding for our special programs that we are trying to launch in our local chapters which would provide increased public education and awareness programs for our geriatric patients and whatever else they can provide in terms of funding for special programs for our geriatric population.

This is one of the aspects that the National Dental Association used to address and approach this problem.

The CHAIRMAN. One way the pharmaceutical manufacturers could assist you and your clientele and the groups that all of us work for is to not be so greedy and to try to give us a better price on prescription drugs. They can do it. That would help all of us. It would help this whole country, and I am hoping that we are headed that way.

Congressman Stokes.

Mr. STOKES. Thank you very much, Mr. Chairman.

Dr. Johnson, one of my concerns would be the fact that in medical schools, we understand that medical students are not being given the proper amount of training with reference to gerontological problems related to the elderly. If that is true, then certainly the gerontological problems relative to the aging minority population is even more true.

Given that fact, I am wondering whether or not your organization is doing anything to try to address this problem?

Dr. JOHNSON. Congressman Stokes, you will notice in part of our testimony that the NMA has put forward the notion very strenuously that all medical schools really are going to have to institute gerontological programs within each medical school where all medical students and whoever else relates to the health system, which is allied health as well, are introduced at the correct level about things which pertain to the elderly since they really are a separate group with many specialized kinds of problems which we are very sensitive to. That is one of our hallmarks in trying to get this off the ground in cooperation with the American Medical Association and other like groups to make sure this comes to reality in the shortest possible time. We are working toward that goal very feverishly at this point.

Mr. STOKES. Thank you very much.

I have no further questions, Mr. Chairman.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Mr. Chairman, this is an extremely expert panel of health care professionals, each with particular expertise in an identified specialty. Unhappily, we often are told that we are living with limited resources. We will find out tonight or tomorrow, I guess, just how limited those resources are supposed to be.

Notwithstanding that, I am forever like yourself, Mr. Chairman and Congressman Stokes, an optimist believing that if we make a good enough case, we can get something done. We can find the money to pay for it. We can rearrange our priorities, but our case has to be as solid as we know how to make it.

With that preamble, what I would like to ask is: As you think of all the things we could do to attack the problems you have been talking about, what should be our one or two top priorities? The reality is that we probably are not going to be able to do everything we want to do.

Let me start with Dr. Johnson, if I may, and work my way down the table.

Dr. JOHNSON. Senator Heinz, I would be very pleased to answer that question because the National Medical Association has as its number one agenda item, literally, to bring access to health care to

every American alive in this country today. We are talking about, so far, 30–40 million faceless people that everyone appears to be discussing when statistics are cited who are very ill and have absolutely no access to health care when we are spending 11.6 or 11.7 percent of our gross national product to the tune of $650 billion—we are well aware that in many instances, Senator Heinz, that sometimes reprioritization instead of reappropriation is sometimes all we need to do to make sure that vaccine gets to the needed kids who do not have access because someone is doing transplants.

Make sure that the NMA is for transplantation, Senator, but we recognize that there are many other things that provide a much better quality of life to a person who is going to contribute to the gross national product instead of many of those who are going to be continuously taking away from it. Therefore, reprioritization in many cases would save us some dollars.

And those 30 million—it would be amazing that, once those people had access, many of the premiums that most of us are paying which are never considered are because we are paying for those people who do not have access, which is ludicrous. The U.S. Senate and House is going to have to come to grips with the fact that the real challenge is to make sure everyone has access to health care in this country.

Senator HEINZ. Dr. Johnson, Senator Pryor, Congressman Stokes and I all served on the Pepper Commission together, and that was half of our mission, to assure access to care. The other half was to deal with long-term care.

As you well know, the Commission was badly divided and split on the issue of how to go about providing access. Indeed, if you only looked at the congressional members of the Commission, what emerged as the majority, Senator Rockefeller's proposal, was actually defeated by a vote of seven to six by the congressional members of the Commission, notwithstanding the fact that I think it can be said that every single member of that Commission, the congressional members, have very good records, very positive records, in terms of trying to meet human needs in the health care area.

No one has ever accused Henry Waxman, Pete Stark, David Pryor, or Max Baucus of being soft on health care.

The CHAIRMAN. I voted for the panel's recommendations.

Senator HEINZ. I understand.

The CHAIRMAN. I was one of the six.

Senator HEINZ. It was very important, I think, for that point to be made.

It is clear to me that we are not going to be able to move the Commission's recommendations this Congress or in toto next Congress. Even the Commission's recommendations provided for a phased-in approach.

A number of us have introduced legislation to expand Medicaid protection for pregnant women and for children through age 18 who live at 200 percent or less of the Federal poverty line. My hope is that the next step would be to move on to an answer that gets rid of the stigma of a means-tested Medicaid program.

Other people, by the way, are advancing other alternatives, some of which are not without some merit. Senator Domenici, the ranking member on the Republican Budget Committee, has advocated

significantly expanding the community health centers network. I don't know what the people in either the inner cities or the rural areas would do for health care were it not for those clinics.

Do you have any advice for us in terms of stopgaps? I am not asking you to retreat from the high ground of access but to get away from rationing health care based on the fatness of one's wallet, which I think is a national scandal. As I said the other day, we have system that heals those who can pay and says to hell with those who can't.

Dr. JOHNSON. Senator Heinz, I must again, in speaking for my organization, say that it is very difficult to tell—you know, we are really talking about my relatives and yours and others who are in the system, the faceless ones who are listed as the 30–40 million that someone keeps talking about although no one knows who they are—if it is possible for us to mobilize and send as many troops to the Middle East as we are talking about, which I am for, Senator, then it is imperative that this Congress recognize that health care in this country is more important than saving oil.

To tell me that we do not have the will in this country to do what is necessary, I don't believe. I really think that if we in the communities start telling our Senators what we want, I think that sometimes they will listen more clearly. I am not sure that the message has been made loudly enough yet.

I am serious. I do not think that piecemeal is the way to solve it. Stopgap is not the way to solve sick people's health problems. Someone must provide resources for them to be taken care of.

This is where it starts, in the U.S. Senate and the U.S. Congress. We really are looking to you all, not for piecemeal or stopgap. We really want the problem solved. [Applause.]

Senator HEINZ. Any other comments on that question from the other members of the panel?

Ms. GEORGES. One of the things that I think can be done, Senator Heinz is—you know of the present and projected nursing shortage in the country. That also supposes a problem of accessibility to care for a number of people in this country.

If you look through some of our large cities, the public institutions that provide services to, again, the most vulnerable in our communities, have the least number of qualified professional nurses on staff. I think this country needs to pay attention to the fact that, as its population shifts, we are going to have to look at minorities for the provision of nursing services in the next century.

However, black registered nurses, only represent 3.6 percent of 2 million registered nurses in the country. That is a shame.

There are people out here who want to be registered nurses. Ask the executive director of National Black Nurses how many letters are now sitting in our office from one comment made in the "Essence" magazine about nursing as a profession. Therefore, government needs to re-look at the funding of nursing programs and providing dollars to those institutions who have a very high retention and graduation rate for registered nurses.

We see this in the National Black Nurses' Association as a priority that must start today, or by the year 2000 there will be no one to take care of us.

Senator HEINZ. That is an excellent suggestion. In your experience, are there some institutions that are clearly outstanding in doing that?

Ms. GEORGES. Yes. They are scattered throughout the Nation.

I want you to know that the majority of black nurses who hold baccalaureate degrees in this country come from Historically black colleges. [Applause.]

They are also the ones who hold the earned doctorates.

Senator HEINZ. Are there any institutions other than the historically black colleges that are doing a good job?

Ms. GEORGES. Yes. I am being very biased since I work there, but the City University system in New York, the University of Illinois system in Illinois, the Cal State system in California.

The CHAIRMAN. He is hoping you will say something is in Pennsylvania. [Laughter.]

Ms. GEORGES. His State is not one of the greatest.

Senator HEINZ. As a matter of fact, if she does, her veracity is going to be called into question. [Laughter.]

I have not put the Philadelphia area institutions under a microscope, but I did put the University of Pittsburgh, in my hometown, under a microscope and found them falling short in that area.

Ms. GEORGES. Very lacking; very much so.

Senator HEINZ. All right, thank you, Mr. Chairman.

Dr. JOHNSON. May I make one other suggestion?

The CHAIRMAN. Yes, Dr. Johnson.

Dr. JOHNSON. Probably, the Congress might want to take a look at hospitals which are located in various communities around the country and owned by the Federal Government, such as Public Health and Veterans Administration hospitals, in order to make health care accessible to those where they are. Since Government has gotten to be such a very large part of the health care scene, those facilities might have some relevance in giving access to health care in some areas where there is a scarcity of resources.

There is one area, again, that you can look at that the Government already posesses in the sense that they control it. Now, everyone cannot go there for a lot of reasons, and we might want to start looking at the fact that, since the Government owns those hospitals, we really might want to take another look to see how they can be fitted into the total health care delivery system.

The CHAIRMAN. Dr. Harper.

Ms. HARPER. I just wanted to dovetail under what Ms. Georges was saying about the Federal Government being able to provide more substantial funding for the education of trained professionals that are in the geriatric field.

If we are going to be able to increase the numbers of providers who are devoted to caring for the geriatric population, it means that we are going to have to provide a cadre of highly trained experts in the geriatric field to teach and train our students on an undergraduate and postgraduate level to send them into these cities where you are putting up these health clinics. It is not enough to just put a body in a health clinic where there is a large geriatric population. It takes a very special training program, a very special and dedicated type of health care provider, to be able

to render the assistance and the service that these patients really need.

The CHAIRMAN. Dr. Harper, you and Senator Heinz have hit on one of the most sensitive areas in this whole system. That is the lack of training in geriatrics and gerontology.

Senator HEINZ. It is appalling. We do not have the teachers to teach the teachers we are going to need.

The CHAIRMAN. That's right.

Ms. HARPER. We have to provide scholarships to train these students. There are students out there that want to learn that cannot afford to pay for their own education.

There are black prospective medical students, dental students, nursing students, and pharmacy students who have the mind, the intellect, and the will. They do not have the money. We need to provide those students with scholarship funding to work with the national organizations that you have gathered here so that they can provide role model services in local areas, help fund their career fairs and their science fairs, and help them to encourage young black students to be able to stand on their own and have the will and motivation to even be able to apply to our health professional schools.

The CHAIRMAN. Dr. Hill.

Mr. HILL. I would like to urge Congress to facilitate and support programs that get the health care providers to talk to each other on a regular basis in forum where the various associations come together to provide continuing education programs and do some research together to discover better ways of caring for these people.

The CHAIRMAN. Isn't in amazing how in this country and especially in this town we don't talk to each other? Or if we talk, we don't listen to each other. That is a wonderful suggestion.

Congressman Stokes, I think we will dismiss this panel at this time. This has been an excellent panel.

Let's give this panel a nice hand of appreciation. [Applause.]

We will now call to our witness table this morning Ms. Shirley Bagley, Assistant Director, Office of Special Programs, National Institute on Aging, National Institutes of Health in Bethesda, MD.

Ms. Bagley, we appreciate your being here and look forward to your statement.

## STATEMENT OF SHIRLEY BAGLEY, ASSISTANT DIRECTOR FOR SPECIAL PROGRAMS, NATIONAL INSTITUTE ON AGING, NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD

Ms. BAGLEY. I would like to thank you for this opportunity to discuss the health care needs of our Nation's black elderly. I am representing the National Institute on Aging (NIA) of the National Institutes of Health (NIH). This institute has responsibility for the conduct and support of biomedical, behavioral, and social research and training related to the aging processes and of diseases and other special problems and needs of the aged.

Among the priority research areas of the Institute, that of minority aging has been a longstanding priority. The NIA supports research on ethnic and cultural variations among older people which ranges from clinical investigations of disease and chronic condi-

tions to studies of social interaction. We currently support studies of differences between minority and nonminority populations through ongoing epidemiological studies of life expectancy and mortality, physical and behavioral functioning, hypertension, cancer, and diabetes, just to name a few areas.

Research has documented that minorities differ substantially from the overall population in many respects, including longevity, health status, living arrangements, health care and service utilization, and health related behaviors. Often, studies show minority individuals to be disadvantaged compared to nonminorities.

Data are not available, however, that adequately characterize older minority populations either for specific conditions and disease processes, for healthy aging, for family life, or for work and retirement patterns, as well as other aspects of later life. Substantial efforts targeted to black, Hispanic, Asian, and native American populations are needed to build a knowledge base for dealing with the special problems and needs of these populations.

An important question is: What do we know about the health status and health problems of older blacks? Second, what does this information suggest about interventions to improve the health status of older blacks? We certainly do not have all the answers to these questions, but we are beginning to accumulate relevant data.

While years of life expectancy have increased for blacks, there has not been a proportionate increase in overall quality of life. The increasing numbers of black elderly will raise concerns about how best to meet the health care needs of these individuals.

Blacks over the age of 65 are more than twice as likely as whites to perceive their health as poor. Although blacks have a greater need for health care, they typically receive less. Blacks have in general less health insurance coverage for meeting the financial costs associated with obtaining health care. In addition, the presence of perceived and actual psychological, social, and structural barriers is an important factor to be considered, and ways of dealing with these problems must be developed in order to increase utilization of health services.

Improving the quality of life, including meeting the health care needs of older blacks, depends on improved and expanded research on this population. The NIA is undertaking such research through a number of new initiatives.

We plan to issue in the near future a request for applications dealing with the epidemiology of conditions responsible for physical frailty in older minority populations. Of interest, will be studies of the prevalence and incidence of conditions responsible for impaired physical functioning which contributes to loss of independence and to increased long-term care needs.

Also of interest, will be the biological, nutritional, and environmental factors affecting severity and progression of these conditions and the relationship of specific functional impairments to severity of specific degenerative conditions in minority populations. Arthritis, congestive heart failure, and diabetes are conditions of special interest. We expect to fund research related to this initiative in fiscal year 1991.

In subsequent requests for applications, we plan to focus research on long-term care in minority elderly. Studies providing in-

formation on factors that contribute to differential use of long-term care services by minority and nonminority elderly will be solicited. Through such research, we hope to obtain, for example, information relating to the relatively low use of nursing homes by black elderly.

We are also interested in supporting research on religious organizations as a source of support for minority elderly. Current studies suggest that churches and other religious organizations play a significant role in the social support, care, and well-being of minority elderly. Learning more about the nature of such support will allow for greater enhancement of this support and its coordination with other sources of support.

Additional research initiatives focusing on minority elderly will be established over the coming years. One of these may well focus on strategies of health promotion and disease prevention in older blacks, since prevention of disease is a most effective means of improving health status. Lifestyle changes, including improved nutrition habits, regular physical activity, smoking cessation, and participation in programs of medical screening can contribute greatly to improved health status. Data indicate that older blacks do not receive enough early, routine, and preventive health care. To the extent that we can encourage use of and delivery of such care, we can prevent disease or prevent further decline or deficits as a result of disease.

The need for more researchers and health care personnel sensitive to cultural and ethnic characteristics to conduct research and provide health and social services to minority elderly is imperative. The NIA is attempting to provide increased training opportunities for minority scientists interested in research on aging, or specifically in research on minority aging. Such opportunities include expanded recruitment efforts to attract blacks and other minorities to research training programs, specialized award programs such as those for pilot research, and supplements to ongoing research projects specifically for minority investigators.

The NIA will continue to develop initiatives in training and research in the area of minority aging. These initiatives will have as an ultimate goal the improvement of quality of life for minority elderly, improvement of health status, and maintenance of independence.

[The prepared statement of Ms. Bagley follows:]

# PROFILES IN AGING: MEETING THE HEALTH CARE NEEDS OF OUR NATION'S BLACK ELDERLY

TESTIMONY OF

MS. SHIRLEY P. BAGLEY
ASSISTANT DIRECTOR FOR SPECIAL PROGRAMS
NATIONAL INSTITUTE ON AGING
NATIONAL INSTITUTES OF HEALTH

BEFORE
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
AND
THE CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST

SEPTEMBER 28,1990

Members of the Committee and Congressional Black Caucus Health Braintrust thank you for this opportunity to discuss the health care needs of our Nation's Black Elderly.

I am Shirley Bagley, representing the National Institute on Aging which has responsibility for the conduct and support of biomedical, behavioral and social research and training related to the aging processes and of diseases and other special problems and needs of the aged.

Among the priority research areas of the Institute, that of minority aging has been a long-standing priority. The NIA supports research on ethnic and cultural variations among older people which ranges from clinical investigations of disease and chronic conditions to studies of social interaction. We currently support studies of differences between minority and non-minority populations through ongoing epidemiological studies of life expectancy and mortality, physical and behavioral functioning, hypertension, cancer, and diabetes, to name a few examples.

Research has documented that minorities differ substantially from the overall population in many aspects, including longevity, health status, living arrangements, health care and service utilization, and health-related behaviors. Often, studies show minority individuals to be disadvantaged

compared to non-minorities. Data are not available, however, that adequately characterize older minority populations either for specific conditions and disease processes, for healthy aging, for family life, or for work and retirement patterns, as well as other aspects of later life. Substantial efforts targeted to black, Hispanic, Asian and Native American populations are needed to build a knowledge base for dealing with the special problems and needs of these populations.

An important question is, What do we know about the health status and health problems of older blacks; and what does this information suggest about interventions to improve the health status of older blacks? We certainly do not have all the answers to these questions, but we are beginning to accumulate relevant data. Older people are a rapidly increasing segment of the black population, since life expectancy for blacks has increased substantially over the last 40 years. In 1940 life expectancy was just over 50 years, in 1985 it had increased to 65 years. It is projected that by the year 2020 blacks over age 65 will constitute approximately 12 percent of the total black population. In 2020 whites over age 65 will comprise nearly 19 percent of the total white population. The greatest proportionate growth for both blacks and whites will be in the oldest-old categories (those age 85 and over). While years of life have increased for blacks, there has not been a proportionate increase in overall quality of life. The increasing numbers of black elderly will raise concerns about how best to meet the health care needs of these individuals.

Cohort data for cause-specific mortality and morbidity over the last four decades suggest the presence of accumulated defects across early segments of the individual life course. These deficits place black older people at greater risk for morbidity and mortality than whites of comparable ages. Changes in lifestyle, reductions in environmental risks, and medical interventions can positively affect the quality of life in current cohorts of older black adults.

Blacks over the age of 65 are more than twice as likely as whites to perceive their health as poor. Current major causes of mortality in older blacks include heart disease, cancer, accidents, and cerebrovascular disease. Increased burdens of illness across the lifespan can have important consequences, not only for the individual, but also for the nature and composition of the family and others in the social and economic support networks. Although blacks have greater need for health care, they typically receive less. Blacks have, in general, less health insurance coverage for meeting the financial costs associated with obtaining health care. In addition, the presence of perceived and actual psychological, social and structural barriers is an important factor to be considered, and ways of dealing with these problems must be developed in order to increase utilization of health services.

Improving the quality of life, including meeting the health care needs of older blacks, depends on improved and expanded research on this population. The NIA is undertaking such research through a number of new initiatives. We plan to issue in the near future a request for applications dealing with the epidemiology of conditions responsible for physical frailty in older minority populations. Of interest will be studies of the prevalence and incidence of conditions responsible for impaired physical functioning in routine daily activities; the biological, nutritional and environmental factors affecting severity and progression of these conditions; and the relationship of specific functional impairments to the conditions in minority populations. Arthritis, congestive heart failure, and diabetes are conditions of special interest. We expect to fund research related to this initiative in fiscal year 1991.

In subsequent requests for applications we plan to focus on research on long-term care and minority elderly. Studies providing information on factors that contribute to differential use of long-term care services by minority and non-minority elderly will be solicited. Through such research we hope to obtain, for example, information relating to the relatively low use of nursing homes by black elderly.

We are also interested in supporting research on religious organizations as a source of support for minority elderly. Current studies suggest that churches and other religious organizations play a significant role in the social support, care and well-being of minority elderly. Learning more about the nature of such support will allow for greater enhancement of this support and its coordination with other sources of support.

The NIA is also interested in expanding studies of Alzheimer's disease and other dementing diseases to include more minority groups. Currently, there is some ongoing research devoted to examination of differences in whites, blacks and Hispanics and the frequency and characteristics of several dementing diseases, multi-infarct dementia, and Parkinson's disease.

Additional research initiatives focussing on minority elderly will be established over the coming years. One of these may well focus on strategies of health promotion and disease prevention in older blacks, since prevention of disease is a most effective means of improving health status. Lifestyle changes to include improved nutrition habits, regular physical activity, smoking cessation, and participation in programs of medical screening or clinical preventive services can contribute greatly to improved health status. Data indicate that older blacks do not receive enough early, routine and preventive health care. To the extent that we can encourage use of and deliver such care we can prevent disease, or prevent further decline or deficits as a result of disease and other chronic conditions.

The need for more researchers and health care personnel sensitive to cultural and ethnic characteristics to conduct research and provide health and social services to minority elderly is imperative. The NIA is attempting to provide

increased training opportunities for minority scientists interested in research on aging and/or research on minority elderly. Such opportunities include expanded recruitment efforts to attract blacks and other minorities to research training programs, specialized award programs such as awards for pilot research, and supplements to existing research projects for minority investigators.

The NIA will continue to develop initiatives in training and research in the area of minority aging. These initiatives will have as an ultimate goal the improvement of quality of life for minority elderly, improvement of health status, and maintenance of independence.

Mr. STOKES [assuming Chair]. Thank you very much, Ms. Bagley. We appreciate very much your testimony.

One of my major concerns revolves around the question of studies, research, et cetera. As you gave us in your formal testimony, you obviously are making some very important studies and important research in certain specific and necessary areas.

I think this is important. In my function as a member of the Appropriations Subcommittee on Labor, Health, Human Services, and Education, I frequently have an opportunity to question those witnesses who come before that appropriations subcommittee with reference to these obvious disparities between white and black health care. I am frequently told—when I ask, for instance: why is it that blacks have more cancer on a comparative pro rata scale than white Americans do, and do we know the reasons for it? I am invariably told: No, Mr. Stokes, we do not know; we are studying this, this, and that. I get this whether I am talking about cardiovascular disease, heart attack, stroke—all of these areas.

At the same time, I am confronted with the fact that I don't know of any group of Americans that have been studied more than black Americans have been studied. We have been studied for everything you can study people for. [Applause.]

The 1985 Secretary's Health Task Force was probably the most comprehensive indepth study ever done in terms of the differential between black and white health care in America. We spent 1 year doing that study with some of the finest minds in the country doing that study.

It is frustrating to constantly be met by the fact that, in spite of all these studies, we just do not know anything about why black people are dying and why they suffer with diseases greater than the other population of this country. So I guess that my question to you is: In addition to your studies and research, do you have the capacity to be able to make recommendations and to effectuate change?

Ms. BAGLEY. That, Congressman Stokes, is the goal of our research: to be able to effect change. We are supporting some research that does provide information on medical interventions or social interventions that we could put in place to improve the health status and quality of life of our older citizens.

Some of this research is looking at, for example, the role of regular routines of physical activity and its impact on maintaining health through maintaining desirable weight and also improved nutritional status. We do not have a lot of research accumulated of this relationship, but we are beginning to get into place some building blocks that we hope will lead to further research.

Mr. STOKES. One further question, and then I will yield back to our chairman.

In your formal statement, you say blacks have in general less health insurance coverage for meeting the financial costs associated with obtaining health care. One of the things that Senator Pryor, Senator Heinz, and I learned when we were working on the Pepper Commission was that there are 40 million Americans who have no health insurance of any kind.

In those 40 million is a large and disproportionate share of minority Americans, in particular, black Americans. Of course, that

is in conjunction with your own statement that even of those who do have it, blacks have less health insurance of those who do have it. Obviously, that is an area in which a large part of the problem lies.

Have you done extensive study in that area and can you elaborate a little more on that?

Ms. BAGLEY. We have not done extensive research in that area, but we have done some research. That research is looking at the interaction of older blacks, for example, in the health care system; what some of the barriers are that affect utilization of services and how some of these barriers may be overcome.

Some research is looking particularly at attitudes of older blacks toward health care personnel and how we might increase the sensitivity of health care personnel to the specific health care needs of older blacks. We are also looking at lifestyle, habits, and behaviors of older blacks in an attempt to increase these behaviors more in the direction of health-promoting behaviors.

Mr. STOKES. Thank you very much, Ms. Bagley.

I yield back to our distinguished chairman.

The CHAIRMAN [resuming Chair]. Senator Heinz.

Senator HEINZ. Mr. Chairman, I have just one question for Ms. Bagley.

I have a hunch that one of the reasons that minorities do not access the health care that may be available to them is that for many years, going back decades and generations, the medical establishment in this country has been largely white. It has been largely uneducated about, insensitive to, or indifferent to both cultural and medical needs of minorities. It is a fact of life that research on sickle cell lagged for years simply because the medical establishment was not black.

The question I have is: To what extent are prior experience and cultural barriers a bar to the elderly minorities seeking medical care? Of course, the question could be expanded more broadly, but you are of the National Institute on Aging, so I will confine my question to the black elderly. To what extent do they view the present health care system as foreign, inimicable, insensitive, something that is not really relative to their needs?

Ms. BAGLEY. That certainly is true in some instances. There is also the case that blacks may not recognize symptoms of disease as early as some other groups in our population and may also not be sensitive enough to then obtain medical care as these symptoms arise.

Also, there is the case that the health care system may not be organized in such a way that it facilitates easy access by older blacks or older minorities in general. First of all, there is a problem of location. Facilities may not always be located in the neighborhoods or in locations that are easily accessible by older blacks.

Then there is the formality that is associated with many health care systems that older blacks do not have great experience in dealing with. The necessary red tape, they find a problem as well as some of the attitudes of the health care personnel, which may be viewed as impersonal and "cold."

We are supporting considerable research on informal health care provided to older blacks primarily by family and friends. In some

cases, this informal care has supplanted the care that might have been provided by the formal system. One of the things that we would like to do is to get a better understanding of the nature of this health care provided by families and friends, so that we can then integrate it more fully into the formal health care system.

Senator HEINZ. Do you have any particular suggestions or recommendations you would make to us?

Ms. BAGLEY. Regarding utilization of health services, I certainly think that the training of personnel including more trained minorities in the health care system is an important factor in increased utilization by older blacks. We are supporting a study in Durham, NC, of a group of community living older blacks. There are also whites in the study, but it is predominantly a study of black aging. One of the things that is being looked at particularly there is the incidence of disease chronic conditions and the related utilization of the health care system. Studies such as this will give us more information on recommendations that we could make in regard to health service utilization, and how it may be improved.

Senator HEINZ. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Bagley, a few moments ago, Dr. Hill made what I thought was a very constructive recommendation, and I would like to get your comments. You run the special programs in Bethesda.

Dr. Hill suggested that we sit down and talk about these things more and communicate more. Do you find that there is greater communication or less communication today than, say, a few years back? Are we all getting together and talking about this network out there or what is available or not available or what we could be doing more of or what we should be putting priorities on or how we might interface some of these programs? What is happening out there and how can we improve it?

Ms. BAGLEY. I think that in general we are talking more than we were at one time, certainly throughout the Federal Government in terms of agencies with programs related to aging. There is now an informal means for interaction and exchange of information through an ad hoc committee on research on aging.

We are also supporting more conferences, symposia, and workshops on the topic which provide a means for exchange of information. Even in view of ongong activities, I am sure that there is additional need for our talking to each other.

There is an ongoing exchange of information and there have been descriptive studies of minority aging. What we need now is to put to use that information that we have been able to accumulate, which is not fully utilized.

The CHAIRMAN. Kind of like Congressman Stokes said: There have been enough studies. Now we have to take what we have found and put that to use.

Our very fine staff director of the Special Committee on Aging, Portia Mittelman—I always embarrass her—Portia is my good friend and also a constituent of mine from Arkansas, and she has been our staff director here. She conceived the idea of trying to informalize many of the Aging Committee hearings.

I might say this for Congressman Stokes' sake. This year, I think, we have had three or four of what we call forums. We do not have witnesses down here at the table and Senators up here propounding questions and reading long statements. We all sit around one big round table, the Senators and the people together, and we just sort of bat ideas back and forth.

I think that is a very constructive method of communication. I hope we will adopt more of that in the future.

We thank you for your appearance, your statement, and your constructive suggestions. Thank you, Ms. Bagley.

Ms. BAGLEY. Thank you. [Applause.]

The CHAIRMAN. We will call our next panelists: Mr. Gorham L. Black, Jr., Senator Heinz' constituent form Harrisburg, representing the National Caucus on Black Aged; and Dr. George Davis, the executive director of the National Black Aging Network from San Francisco. We look forward to both of your statements and thank you for appearing today.

Mr. Black, we will hear from you first.

## STATEMENT OF GORHAM L. BLACK, JR., COCHAIRMAN, NATIONAL CAUCUS AND CENTER ON BLACK AGED, HARRISBURG, PA

Mr. BLACK. Thank you, Mr. Chairman. Senator Pryor, we thank you from NCBA for your citing the work of NCBA in helping to prepare for these hearings. We were pleased to do it.

Senator Heinz, I would like the record to reflect my personal appreciation for your plaque this morning. It was quite a surprise to me, I assure you.

Congressman Stokes, you have long been a supporter of NCBA, and we appreciate that.

We appreciate the opportunity to testify at this hearing on Profiles in Aging America: Meeting the Health Care Needs of the Black Elderly, and we commend you for holding this hearing on a subject that deserves more attention.

NCBA fully recognizes that your time is limited. Consequently, I shall limit my presentation to 5 minutes as you have requested.

NCBA recently completed a report on the health status of aged blacks. With your permission, I request that this report be made a part of today's hearing record.*

The CHAIRMAN. We will make that report a part of the record, Mr. Black.

Mr. BLACK. My testimony will concentrate on two major subjects this morning. First, in the interest of time, I shall summarize some of the major points in the NCBA report on the health status of aged blacks. Second, NCBA will propose some recommendations to enable our Nation to obtain a better understanding of the health status of elderly blacks in the United States.

One of the key findings in the recent NCBA report is that elderly blacks have poorer health than older whites by virtually any recognizable standard of measurement. The harsh reality is that a racial health gap exists between white America and black America. Some improvements have been made, but sharp differences still exist.

One of the most readily apparent is the significantly shorter life expectancy for blacks than whites. A mortality crossover does

*See appendix, p. 115.

occur at more advanced stages. However, the difference in life expectancy between blacks and whites during the early, middle, and much of the later years of life, provide compelling evidence that the health status for aged blacks is noticeably poorer than for elderly whites.

Older blacks have been shortchanged to a large degree by our health care system. In my written testimony, there are a number of statistics which have been covered by previous speakers and, I note, around the room on some of our charts, so suffice it to say that those statistics will illustrate the point that blacks have been shortchanged by the system.

Accessibility to health care is still a major problem for older blacks despite enactment of Medicare and Medicaid. Both Medicare and Medicaid provide valuable protection for elderly blacks and other elderly Americans, but these programs have crucial gaps in coverage. Aged whites are more than twice as likely to close or at least partially close these gaps through the purchase of private health insurance than elderly blacks.

A National Center for Health Statistics survey reported that 79 percent of whites 65 or older had private health insurance in 1986 compared to just 38.5 percent for aged blacks. This statistic, I think, has also been repeated by a number of our preceding witnesses.

Affordability is also a major health care problem because elderly blacks are among the most economically deprived groups in our society by whatever barometer one chooses to use. The proverty rate for aged blacks is more than three times as great as for elderly whites. In addition, hundreds of thousands of older blacks have incomes teetering on the edge of poverty.

Rapidly rising health care costs have intensified problems for aged blacks. Health care expenditures have increased well above the inflation rate for several years now.

This development has placed elderly blacks in a dilemma. Critical daily needs have forced aged blacks to compromise their health care. Do they buy food or prescription drugs? Do they pay the rent or have a doctor check a nagging ailment which has already lingered too long?

For the final leg of my presentation, I shall focus on NCBA's short-term recommendations to enable our Nation to have a better understanding of the health status of aged blacks and to adopt measures to improve their health status.

One is improved data collection. Our number one recommendation is to improve the data collection process to assure more accurate, complete, and current information about the health status of elderly blacks. Some of our preceding witnesses have alluded to studies. We emphasize the collection of the data from those studies. I think that will be one of the best recommendations that we can put forward today.

We have been frustrated about the paucity of current and accurate data. We have other recommendations in the prepared testimony.

I do again commend the Committee for bringing this subject to the forefront. We look forward to working with you to improve the health status of older blacks.

Thank you.

[The prepared statement of Mr. Black follows:]

TESTIMONY BY

GORHAM L. BLACK, JR
CO-CHAIRMAN
NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

Senator Pryor, Senator Heinz, Congressman Stokes, and Members of the Senate Committee on Aging and the Congressional Black Caucus Health Brain Trust, the National Caucus and Center on Black Aged appreciates the opportunity to testify at this hearing on "Profiles in Aging America: Meeting the Health Care Needs of the Black Elderly." At the outset, we wish to commend you for holding this hearing on a subject that deserves more attention.

NCBA fully recognizes that your time is limited. Consequently, I shall limit my presentation to five minutes, as you have requested.

NCBA recently completed a report on the "Health Status of Aged Blacks." With your permission, I request that this report be made a part of today's hearing record.

My testimony will concentrate on two major subjects this morning. First, in the interest of time, I shall summarize some of the major points in the NCBA report on "Health Status of Aged Blacks." Second, NCBA will propose some recommendations to enable our nation to obtain a better understanding of the health status of elderly Blacks in the United States.

A. Summary of Major Points in NCBA Report

One of the key findings in the recent NCBA report is that elderly Blacks have poorer health than older Whites by virtually any recognizable standard of measurement. The harsh reality is that a racial health gap exists between White America and Black America. Some improvements have been made, but sharp differences still exist.

One of the most readily apparent is the significantly shorter life expectancy for Blacks than Whites. A mortality crossover does occur at more advanced ages. However, the differences in life expectancy between Blacks and Whites during the early, middle, and much of the later years of life provide compelling evidence that the health status for aged Blacks is noticeably poorer than for elderly Whites.

Older Blacks have been shortchanged, to a large degree, by our health care system. I shall cite a few statistics to illustrate my point:

- Older Blacks are much more likely to have a negative perception regarding their health status that aged Whites. Elderly Blacks are almost

twice as likely to consider their health to be poor or just fair than older Whites: 48.2 percent vs. 27.7 percent during 1988.

- o The average number of bed days because of acute or chronic conditions is 55.1 percent higher among elderly Blacks than older Whites: 21.4 days vs. 13.8 days.
- o Aged Blacks have a higher morbidity rate and mortality rate from several diseases than elderly Whites.

Accessibility to health care is still a major problem for older Blacks, despite enactment of Medicare and Medicaid. Both Medicare and Medicaid provide valuable protection for elderly Blacks and other older Americans, but these programs have crucial gaps in coverage. Aged Whites are more than twice as likely to close, or at least partially close, these gaps through the purchase of private health insurance than elderly Blacks. A National Center for Health Statistics survey reported that 79.0 percent of Whites 65 or older had private health insurance in 1986, compared to just 38.5 percent for aged Blacks.

Affordability is also a major health care problem because elderly Blacks are among the most economically deprived groups in our society by whatever barometer one chooses to use. The poverty rate for aged Blacks is more than three times as great as for elderly Whites: 32.2 percent vs. 10.0 percent in 1988. In addition, hundreds of thousands of older Blacks have incomes teetering on the edge of poverty.

Rapidly rising health care costs have intensified problems for aged Blacks. Health care expenditures have increased well above the inflation rate for several years now. This development has placed elderly Blacks in a dilemma. Critical daily needs have forced aged Blacks to compromise their health care. Do they buy food or prescription drugs? Do they pay the rent or have a doctor check a nagging ailment which has already lingered too long?

## B. Recommendations

For the final leg of my presentation, I shall focus on NCBA's short-term recommendations to enable our nation to have a better understanding of the health status of aged Blacks and to adopt measures to improve their health status.

### 1. Improved Data Collection

Our number one recommendation is to improve the data collection process to assure more accurate, complete, and current information about the health status of elderly Blacks. Consequently, we are making a special plea to the Senate Committee

on Aging and the Congressional Black Caucus Health Brain Trust to use your good offices to gain assurance that a focal point will be established in the federal government for the collection and keeping of comprehensive data regarding the health of older Blacks. The Administration on Aging or the National Institute on Aging, NCBA believes, would be ideally positioned to assume this responsibility. If legislation is required to implement this recommendation, NCBA stands ready, willing, and able to work with the Senate Committee on Aging and the Congressional Black Caucus Health Brain Trust. If we can achieve this objective administratively, we are prepared to assist in whatever way we can.

NCBA has been frustrated about the paucity of current and accurate data in the federal government concerning health and the Black elderly. Today only a small amount of statistical data exist on the health status of older Blacks. When information is available, it frequently applies to Blacks in general. The net impact is that any analysis at this stage must, at best, be a superficial attempt to assess the health care crisis which already affects too many older Blacks.

2. Other Recommendations

In addition, NCBA urges implementation of the following recommendations:

- Every effort should be made to protect aged Blacks and other low-income older Americans from having their benefits cut back when savings plans are adopted for Medicare and Medicaid. Elderly Blacks and other older Americans have been hard hit by cutbacks in Medicare and Medicaid during the 1980's. Cost containment should be the primary goal, rather than benefit reductions.
- New initiatives should be developed to promote preventive measures to ward off illness and to encourage wellness among older Americans.

Educational efforts are needed concerning appropriate lifestyles and a proper diet to enhance the likelihood for healthier living. Additional educational efforts are necessary concerning the hazards of smoking and excessive alcohol consumption.

C. Conclusion

In conclusion, NCBA appreciates the opportunity to testify at this hearing. We wish to commend you again for bringing this subject to the forefront. We look forward to working with you to improve the health status of older Blacks.

Before concluding my presentation, I would like to ask permission to insert in the hearing record two brief statements on "Controlling Prescription Drug Prices Under Medicaid" and "Eliminating Discriminatory Practices in Nursing Homes" . Because of time limitations, I did not include these subjects in my presentation. However, I think that it would be helpful to have these statements in the hearing record.

Thank you. I shall be glad to respond to any questions that you may have.

The CHAIRMAN. Thank you, Mr. Black. We are going to put not only the full text of your statement, but also the other material that you requested be included into the record. We are going to build a complete hearing record this morning.

We very much appreciate your being here.

Mr. BLACK. Thank you, sir.

The CHAIRMAN. Dr. George Davis, we appreciate your coming all the way from San Francisco. You have come a long way and we thank you for your appearance.

**STATEMENT OF GEORGE DAVIS, NATIONAL EXECUTIVE DIRECTOR, NATIONAL BLACK AGING NETWORK; EXECUTIVE DIRECTOR, BAYVIEW HUNTER'S POINT MULTIPURPOSE SENIOR SERVICES, SAN FRANCISCO, CA**

Mr. DAVIS. Thank you, Senator Pryor, Senator Heinz, Congressman Stokes. Thank you very much for having NBAN be a part of this. We are very honored.

I would like to take a little different approach in my presentation to tell you what it is really like to be growing old as a black American in this country.

Please visualize with me the unique journey of growing old as a black American. It is a journey filled with highs and lows, a journey that must be undertaken with a certain boldness of spirit. It is a journey whose rewards are often difficult to explain, but are immeasurable and worthwhile.

Unfortunately, in the journey of the black elderly, far too often the easy path is blocked by huge stumbling blocks of poverty forcing them to a secondary trail, only to realize that the historic and ongoing neglect of their needs forces them to leave the trail again and again.

In their backpacks, the black elderly have been told that they will find some tools for protecting themselves from the elements along their journey, such as Medicare and Medicaid. However, the chilly winds of the night with their razor sharp ineffective in the face of catastrophic medical needs.

Historically, the last hired and the first fired, their benefits came late and never had a chance to mature, yet, they have stayed on the trail marching through and beyond segregation, discrimination, and overt racism. Midway on this journey, the joy of leaving sharecropping jobs that demeaned their character gave reason for a new hope and a continued faith in God's healing hand. As the old black spiritual says, "There is a light in the valley that outshines the sun."

Life in the inner city has required changes in lifestyle to complete the journey, changes that compromise the dignity and integrity of the black elderly. As black elders approach the golden stage of their journey, the gold is tarnished by hypocrisy and ambiguity.

The finances for this journey are not within their control. Our black elderly come from a tradition where a penny saved is a penny earned, yet today, with all of our advanced technology, we cannot even maintain the value of the pennies they have saved. The black elderly, because they start out poor on their aging journey, pay disproportionately for the failures of a society gone wrong.

Those who live in the inner city in predominantly black neighborhoods, still must pay the highest prices for food at local neighborhood stores. In most of these neighborhoods, they cannot even buy a pair of shoes, have the pleasure of going to a movie, or go to a park in safety to relax and reminisce.

Taxicabs will not even enter many inner-city neighborhoods after dark, leaving the black elderly to face the midnight crisis of their emergency alone. As America fights the monster of drug abuse, we see that the predominantly black inner-city communities are its favorite hunting grounds, and the black elderly are being ravaged by this beast.

They must take up the burden of raising crack-addicted grandchildren. They are holding families together while their children are in drug rehabilitation programs, in the prison system, unemployed, murdered, or in some cases, just plain vanished.

Even in the deep South in rural Mississippi, Alabama, and Louisiana, the black elderly have developed the urban diseases of "iron-bar-itis" and "lock-up-a-phobia." The tragedy of these "diseases" is that they are occurring even in the sanitary areas of our black culture and tradition. These areas, the rural "foot log" communities of the South, are the final frontiers of black culture. We as blacks ought to say something and say it now; that we draw the line here to preserve the black culture and tradition that our elders brought to us.

The National Black Aging Network cannot and will not permit this once graceful aging journey to become any more degrading and inhumane. These black elders are the foundation of our culture and the shapers of our values.

As ours is a "store-front" culture, we propose to open up storefront informational senior centers throughout the United States. They will provide information, referrals, and personal guidance in assessing senior services, adult day health care, social day care, outreach, and care coordination to frail elders to enhance the aging journey of disenfranchised black elders.

My agency, Bayview Hunter's Point Multipurpose Senior Services, located in San Francisco, CA, has already demonstrated a successful model based on this concept, which is unique in the United States. NBAN will certainly build on this model at its national headquarters in Oakland, CA. Due to NBAN's grassroots approach, we are in a unique position to network with existing aging organizations throughout the United States to develop and implement the proactive solution mentioned in my written testimony.

NBAN plans to hold its first national conference in Oakland in 1991. The focus of this conference will be to develop an agenda and tentative timetable to bring these solutions to fulfillment.

In addition, we will invite input on the discussion of other serious problems of the black elderly specifically, as well as the elderly in general. I would like to take this opportunity to extend to you an invitation to attend and participate in this forum.

We at NBAN believe—although we have been studied a lot—we believe in action. In closing, you might wonder if NBAN is undertaking an awesome task, but grassroots advocacy is a rearguard holding action. As foot soldiers in the social trenches of America, we must hold on until the Pepper Commission action is passed fa-

vorably and until those black elderly who are in imminent threat of losing their housing through section VIII evictions are protected; until such time as there is a clear national health policy, we at NBAN feel that our job has just begun.

You must remember that you are at the midpoint in the aging process on your journey.

Thank you.

[The prepared statement of Mr. Davis follows:]

WRITTEN TESTIMONY OF GEORGE W. DAVIS, PHD
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# NEW PERSPECTIVES ON HEALTH CARE ISSUES OF THE BLACK ELDERLY

George W. Davis, Ph.D, Executive Director
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## I. FACING THE CHALLENGE: RELEVANT FACTORS

Addressing the health needs of the Black elderly is a unique and critical challenge facing this country's leaders as they attempt to manage the demands of an aging American society. Black elders have historically been isolated from mainstream health care in the United States. Because they have long been denied access to early intervention and consistent health care services, they are at high risk for premature institutionalization and death at an age much earlier than White elderly of similar age. Several factors influence their accessibility to the current health care system and result in this multiple jeopardy situation.

First, cultural differences often cause medical staff to ignore or overlook significant indicators of medical problems, thus failing to achieve a clear understanding of elders' health problems. Black elders' lack of education or knowledge of medically-oriented terminology may prevent adequate explanation of symptomology. Further, Black elders may overlook or underestimate the importance of symptoms because they have learned to cope with aches and pains in the past when health care was not available to them.

Second, Black elders are the poorest of Americans over age 55, and consequently become victims of the public hospital system with its impersonal and inconsistent medical treatment. They have little choice in the selection of a physician, frequently seeing a different doctor each time they visit a clinic. Such lack of continuity in health care can result in nonexistent coordination of treatment and medications, leaving elders' with no medical professional in whom they have trust.

Third, the life experience of the current cohort of Black elderly has been filled with discrimination, prejudice, fear, and poverty. Since the War on Poverty has clearly been lost, Black communities have suffered significant losses. Most major thoroughfares through Black communities show evidence of empty store-fronts where businesses, unable to turn a profit, have been forced out. They are usually replaced by warehouses, factories, or other types of business that provide no vital resources or services to the residents of the community. When the banks, major grocery stores, and clothing stores leave, secondary services such as doctors, dentists, and pharmacies who depend upon the foot traffic generated by the life-line serivces are also forced out.

In these poorest of communities, transportation services are frequently sparse. Black elders must depend upon family or friends to take them to medical appointments. For rural Black elders, the services never existed, and transportation and access problems are compounded by distance and even lower standards of living. The consequential lack of accessibility to community-based health care services has resulted in an aged population whose health is, in general, worse than other elders. They enter the health care system at a point of crisis, with medical problems that often have advanced to a critical, even terminal, stage.

Fourth, Black elders do not live as long and therefore experience the health problems of aging at an earlier age. The population between age 50 - 60 is the largest population of Black elders, many of whom do not reap the benefits of entitlement programs for elders. The average Black male lives to the age of 65, seven years less than that of White males. He only receives Social Security/Medicare benefits from age 62-65 at a reduced rate. Should the Social Security entitlement age be increased to 65, he would not participate at all. Older Americans Act programs begin at age 60, exculding a large population of Black elders between age 50 - 60.

## II. NATIONAL BLACK AGING NETWORK: CHAMPION OF BLACK ELDERS

The National Black Aging Network (NBAN) developed as a network of grass-roots advocates determined to provide a voice for the needs of the Black elderly. The importance of networking cannot be stressed enough because, historically, the informal Black networking system, the "Black Grapevine", has been the most significant source of information, assistance, and support for Black elders.

In this current era of non-involvment in civil rights by organizations which were developed as a reaction to the lack of civil rights, the networking that once existed among these organizations is severely dissipated and, in some cases, has ceased to exist at all. In many areas, there were community-based organizations developed during the late 60's and the mid-to-late 70's addressing the numerous needs of the Black population. These organizations are no longer in place. The needs, however, are still there.

As a result of the closing of the "traditional Black networking window", the advocacy for historically disadvantaged groups has become fragmented as well. That is to say, racial minority groups have been divided into ethnic minority groups, which have been further divided into special interest groups, i.e., "the Homeless", "the Working Poor", 'the Aged", etc. The net result is that members of racial groups, especially those who are both Black and elderly, have never received that advocacy which they so desperately need. Many of these are individuals are: (1) only two generations removed from slavery, and (2) too far along in their lives to benefit from legislation or affirmative action resulting from the Civil Rights Movement.

One of the goals of the National Black Aging Network is to link, at the grass-roots level, the formal and informal support systems utilized by the Black elderly. Black elders have learned to seek information from people and resources that they know and trust, particularly since the mainstream formal systems have generally ignored them. Usually family or friends, church members, barber and beauty shop operators, neighborhood pharmacists, and clinic physicians are relied upon for advice and information about available services. Word of mouth has always been the primary path of communications within the Black culture, especially among the elderly. From the telephone to the technology of print and voice media, the Black elderly have been excluded from participation thanks to prejudice and poverty. They learned to depend on one another to survive the assaults of life and continue to do so even today.

Of further import is the recognition that the number of homeless Black elders is steadily increasing, and therefore traditional avenues for obtaining information and assistance are not available. Street elders spend their time at liquor stores, fast-food eating places, parks and parked cars, and hanging with other homeless in "drinking dens". For these elders, information about mainstream health care services is totally beyond their reach, and even the more traditional Black support systems often fail to meet their needs.

The multi-generational, extended Black family has always been a traditional source of support and caring for grandparents, aunts and uncles, siblings, and other family members and friends. A successful survival mechanism that served the Black culture well since the days of slavery, the extended family now finds itself torn apart by the ravages of the drug epidemic and violence in the streets. Aging grandparents now become the caregivers instead of being receivers of family care, when parents can no longer provide for their children. Families sustain the tragic loss of children, often even before great grand-parents die. The life experience of the Black youth of today is so far removed from the experience of their grandparents that communication and understanding is strained at best, and non-existent in some families.

Mindful of the lack of inter-generational communication or connection between young Blacks and their aging grandparents, the National Black Aging Network has established NBAN Intergenerational (NBAN-IG), a grass-roots group of youth and young adults working to develop an understanding of the issues facing their elderly family members. Their goal is to create new solutions to address the health care and social needs of the generations which precede them, as well as their own.

## III. IDENTIFYING THE PROBLEMS -- CREATING NEW SOLUTIONS

Often much discussion occurs about what is wrong in this country. Community representatives faced with economic and social challenges voice concerns about the problems facing their particular groups. The National Black Aging Network is undeniably concerned about the mounting difficulties facing the Black elderly today. However, from the vantage point of grass-roots advocates, NBAN sees potential solutions to the problems this society faces and offers them for consideration.

## IV. MEETING THE CHALLENGE: POLICY AND PLANNING CONSIDERATIONS

It is crucial that policy planners understand that Black elders are as heterogeneous as any other population in this country. A diversity of community-based services with consideration for the special needs of the sub-groups that comprise any and all segments within American society, including but not limited to that group identified as the Black elderly, is both a responsibility of our government and a solution to the health care problems of the Black elderly.

The recognition of the importance of traditional Black cultural practices in the delivery of health care to Black elders can not be emphasized enough. Yet because the Black elderly are not a homogeneous population, services must be integrated into both the traditional and non-traditional Black cultural systems. By understanding the strengths of the Black cultural system and including members of that system in the planning and development of community-based health care programs, this country's leaders will have a unique opportunity to achieve far greater success in providing quality health care to Black elders than has ever been realized in the past.

So often the solutions to problems seem to be beyond our reach. Yet we believe there is hope for the future. Our government's priorities in funding need to change. We need to focus on the needs of communities, instead of institutions. We need to train our health professionals to learn more about the culture mores of Black elders and other elders of color. We need to invest in preventive care and reduce expensive institutionalizations. We need to strengthen, rather than weaken, the helping traditions of extended families and non-white racial and cultural groups.

Improving health care for Black elders may not be the "sexy program of the week", but we owe this steadfast group of people a great deal. For they were the harbingers of freedom. They picked cotton in the swealtering heat of the fields. They washed the floors and took care of the children of many fellow Americans. They fought for the right to vote. They stood in the front lines of battlefields from France to Korea to Viet Nam to Mississippi. Today they struggle to keep the Black family together in the midst of the drug epidemic. We can do no less than to provide the quality health care that they so desperately need.

The National Black Aging Network is the vanguard of the new grassrooots advocacy, reaping the benefits of the 1960's, combined with the skills and technology of the 1990's. NBAN is a vehicle to receive funding and resources to provide the research, innovative programming and intergenerational perspectives necesssary to improve the quality of life for Black elders. The programs we design for today's Black elders will be the prototypes for our future generations of elders. Let us develop them with compassion, integrity, and dignity.

## THE BLACK ELDERLY: FACTS AND STATISTICS

* Black Elders remain the fastest growing segment of the Black population. Between 1970 and 1980, the Black elderly population increased 34%, while the total Black population increased only 16%.

* The biggest portion of growth of the older segment of the Black population will be in the 75+ category.

* In 1983, the average life expectancy for white males was 72, compared to 7 years less for Black males at 65. White females had a life expectancy of 79 years, compared to five years less for Black females at 74 years.

* Blacks of extremely old age (75+) have lower mortality rates, but higher poverty rates and illness than Whites.

* In urban areas, 32% of the Black Elderly live in poverty (1 in 3) while 11% of older whites are in poverty (1 in 9). In rural areas nearly 1 out of every 2 Black elderly live in poverty. Over half of all Black elders living alone are in poverty.

* Blacks are twice as prone to get hypertension as Whites. The highest prevelence rate of hypertension among Blacks occurs in the 55-64 age group, where the rate is 51.1 per 100.

* In addition to high rate of hypertension, Blacks have higher rates of heart disease, cerebral vascular disease and significantly higher prevelence of renal disease and renal failure compared to Whites.

* In all age/sex categories, diabetes is 33% higher among Black Americans than White Americans and among Black diabetics eight times more frequent in the highest age group.

* A 1975 study of noninstitutionalized Black and White elders showed Blacks experience twice as many bed-disability days as whites.

* Blacks tend to suffer more from diseases such as arthritis, diabetes and hypertiension which require long term care, rather than acute care or medical services covered by Medicare.

* Only 3% of Black elderly are institutionalized, compared to 5% of White elders. Among the eldest population, only 12% of Blacks live in nursing homes, while 23% of Whites do.

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## THE BLACK ELDERLY: PROBLEMS AND SOLUTIONS

| PROBLEMS | SOLUTIONS |
|---|---|
| **A) LACK OF ACCESS** | |
| 1) Services are often located outside of the community. | 1) Locate health facilities in the Black community. |
| 2) Transportation routes out of the community are cumbersome. Public transit is usually the worst in low-income areas. | 2) Include transportation in planning as a cost of providing services. |
| 3) Public hospitals are overcrowded and understaffed to provide the patience and cultural sensitivity needed to work effectively with Black elders. | 3) Put financial resources into community-based health care. |
| 4) Public clinics move elders from physician to physician, with little or no follow-up. | 4) Follow-up provided by same physician. If regular physician is leaving, case conference should be held with new patient and new physician to assure vital and accurate information is shared between all concerned. |
| 5) Many Black elders have no health insurance outside of Medicare, resulting in an inability to pay for essentials such as medications. | 5) Invest Medicare dollars in prevention, home safety, and medications to delay or prevent long-term problems. |
| **B) UTILIZATION OF SERVICES** | |
| 1) Black elders will often sacrifice their health to retain their dignity. Historically they have had reason to be suspicious of services and and frequently have low or unrealistic expectations of health care/treatment. | 1) Provide culturally sensitive staff and and training for physicians and staff in the area of the Black culture. |

| PROBLEMS | SOLUTIONS |
|---|---|
| 2) Black elders need to trust the health provider or know someone who trusts the provider. | 2) New programs must be given time to develop rapport and acceptance in the community and seek clients through word of mouth. |
| 3) Mistrust and lack of training in how to get results from the system, as well as cultural differences in healing/coping strategies. | 3) Recognition of non-traditional healing methods and incorporation of them into treatment plan. |
| 4) Single, non-married Black males, often with severe chronic or terminal illnesses, do not have the knowledge of resources or ability to advocate for themselves. | 4) Peer counseling for distinctive groups within the Black elderly population, such as single males, street elders, and and the home-bound, to encourage advocacy/service utilization. |
| C) <u>CULTURAL INSENSITIVITY</u> | |
| 1) Many health care professionals are unaware and unconcerned about the Black culture. Since Black elders are the heart of the culture, they are particularly sensitive when their cultural mores are dismissed. | 1) In-service training on cultural sensitivity should be mandatory for health care workers. Also encourage funding of grass-roots programs that understand and promote the history and culture of the Black elderly. |
| 2) Research designs are limited to black/white differences. | 2) Expand the funding base for researchers who specialize in research on the Black elderly and understand cultural variances. |
| 3) African American physicians are leaving family practices to work for large HMO's (usually due to economic factors) and the number of African Americans in medical school is minimal. | 3) Sponsor geriatricians in medical school to specialize in working with Black elderly. Also finance Black gerontologists to network with physicians. |
| D) <u>LACK OF PREVENTION SERVICES</u> | |
| 1) Black elderly often utilize emergency rooms as health clinics. | 1) Bring preventive screening services to Black elders where they meet: churches, pharmacy, grocery store. Mobile vans deliver services to rural elderly and home-bound. |

| PROBLEMS | SOLUTIONS |
|---|---|
| 2) Black elderly frequently do not seek help until a crisis has occurred. | 2) 24-Hour Advice Nurse in community-based health setting who can network with care coordination services to follow up with prevention information. |
| 3) Safety risks in the home, need for adaptive equipment. | 3) Home repair services to prevent accidents in the home and increase level of independence with safety and adaptive equipment. |
| 4) Poor dietary control secondary to low income and lack of access to grocery stores. | 4) Focus on nutrition education within a culturally based diet. Encourage low cost food distribution programs such as Project S.H.A.R.E. |
| 5) Black elders are poor health risks for the upcoming HMO system as they are sicker and in need of expensive care for chronic and multiple health problems. | 5) Recognition and funding of chronic and long-term illness care. |
| 6) Stigma of identifying mental health problems and seeking mental health care. | 6) Locate counseling services in community clinics and integrate with physical health care plan. Must be culturally sensitive and appropriate. |
| E) FAMILY DISINTEGRATION | |
| 1) High unemployment rate and the drug epidemic in the Black community force Black elders into integral positions of keeping the family together as best they can. | 1) Support groups for grandparents who are raising grandchildren in a more complex and volatile era than they raised their own children in. Provide funds for grandparent to take on foster care responsibility as is done for non-familial custodians. |
| 2) Grandparents are now care-givers for grandchildren, as parents are on drugs or incarcerated. | 2) Child-care options available to grandparents with funding and transporation provided for the children. |

| PROBLEMS | SOLUTIONS |
|---|---|
| 3) Children experience psychological complications as parents leave children. | 3) Counseling for teens and youngsters affected by the loss of parent(s) and trying to cope with living with grandparents. |
| F) LIMITED LONG-TERM CARE | |
| 1) Black cultural ethic to keep increasingly frail elders in the home as long as possible for economic reasons and family continuity creates increased stress on the family. | 1) Respite care for caregivers in the evenings, on week-ends, as well as in the daytime for caregivers to maintain their jobs. |
| 2) Limited information about alternatives to nursing homes. | 2) Outreach geared to Black care-givers regarding support systems of community-based care. |
| 3) Lack of community-based services such as adult day health and adult social day services that are geared to a Black elderly population. | 3) Support community-based adult day health/social day and in-home support services in Black communities. Medicare reimbursement for adult day health care. |
| 4) Caregivers in the "sandwich generation" who work as well as care for children and elders get little outside support to help keep an elder at home. | 4) Support groups for caregivers housed in churches and community centers. |
| 5) Families care for elderly members without training about in-home support and care. Elderly today are living with more chronic diseases for a longer period of time and requiring more skilled care. | 5) Training for families/caregivers in the practical aspects of caring for a frail elder in the home. Increasing the role of outreach workers and public health nurses in providing information and education. |
| 6) Nursing homes do not relate to culture of Black elderly. | 6) Funding opportunities to develop Black-owned and operated nursing homes and increase culturally relevant proggramming and care in all nursing homes. |
| 7) Residential hospice services unavailable for elders dying of illnesses other than AIDS or cancer. | 7) Expand Medicare funding for hospice services; expand hospice funding to create more hospice beds for other illnesses. |

The CHAIRMAN. Thank you, Dr. Davis.

The uniqueness of the San Francisco program that you have—is this a federally funded program or State or mixed with local moneys? How is this funded?

Mr. DAVIS. We have a multipurpose senior center which is funded by the city. We have an adult day health care center which is funded by MediCal in San Francisco, and we have an independent elders program which is funded by three foundations with a social day program. We have the full range of social services and we have a very good grassroots social organization where our individuals are out in the community working with those people that we talked about.

The CHAIRMAN. I want to find out more—maybe not at this hearing—but I would love to find out more about this particular program because you may have established a national model out there that we could all look at any maybe emulate.

Mr. DAVIS. Thank you very much.

The CHAIRMAN. Congressman Stokes.

Mr. STOKES. Thank you very much, Mr. Chairman.

Mr. Black, let me start with you for a moment. At the beginning of our hearings, Chairman Pryor paid a special tribute to Sam Simmons, who is the director for your institution, and I want to do that same.

I have had the pleasure, privilege, and honor of knowing Sam since I first came to Washington 22 years ago. At that time, he was an Assistant Secretary at HUD, and an outstanding one at that time. He brings to your organization such talent and expertise and shares it so willingly with those of us who need the benefit of that expertise. I want to, just once again, thank you for not only what the National Caucus does, but also what Sam Simmons does for those of us who need his service here.

Mr. BLACK. Thank you, Congressman Stokes. He would have been here but he is on a trip.

Mr. STOKES. I think I saw him walk in a little while ago. There he is. [Applause.]

Mr. BLACK. Well, I will have to get with Dr. Henry, our cochairman and get him a pay raise for all of those compliments.

Mr. STOKES. He deserves it, I can tell you that.

Let me ask you—your testimony zeroes in on what I was talking about with Ms. Bagley when she testified. In fact, you specifically say to us in your testimony:

> A National Center for Health Statistics survey reported that 79 percent of whites 65 or older had private health insurance in 1986 compared to just 38.5 percent for aged blacks.

That is on page 2.

On page 3, you further give information on this data. You say:

> Affordability is also a major health care problem because elderly blacks are among the most economically deprived groups in our society by whatever barometer one chooses to use. The poverty rate for aged blacks is more than three times as great as for elderly whites: 32.2 percent versus 10 percent in 1988. In addition, hundreds of thousands of older blacks have incomes teetering on the edge of poverty.

This, of course, is something that really highlights the problem that black elderly have in getting access to health care. In fact, you very vividly pointed that out, when you said:

Critical daily needs have forced aged blacks to compromise their health care.

Do they buy food or prescription drugs? Do they pay the rent or have a doctor check a nagging ailment which has already lingered too long?

It is just unfortunate that we live in a country where people, by virtue of happenstance of birth, are forced into these types of options, which are in fact no options at all. I don't know really what we can do about it as I engage in the budget problems that we now have and the types of cuts we are going to be faced with in Medicare and other areas that the black population is dependent upon for good health care. It really presents a real problem and dilemma.

I am just glad your organization is on the scene to try to help give us some type of direction in all these areas. You may want to just speak to that for a moment.

Mr. BLACK. I would only comment in that regard, Congressman Stokes, that as we go about our work in NCBA, we still find ourselves facing a closed door on the availability of data. You made the comment that we have been studied to death, and that is true, but what happens to all of the data that should fall out from those studies? It is like it is going into the Bermuda Triangle—you never see the results of it.

We think that a focal point in the Federal establishment should be established where organizations, Dr. Davis, myself, or others can go and get that data and have it made readily available to us.

Mr. STOKES. I noted that in your testimony. I am glad you mentioned it because I had planned to ask you about it.

I agree with you. We do need a centralized focus on that data and research which has been compiled and is being compiled so that we might not have this sort of shotgun approach that does not really centralize the focus on that which we do know once we have acquired the data.

Dr. Davis, I do not have a specific question for you. I found your testimony fascinating, informational, and instructional, and I want to commend you upon what you are doing out there in California.

Mr. DAVIS. Thank you very much.

Mr. STOKES. Thank you, and I will now yield back to the Chairman.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Mr. Chairman, I know that our time is short. I have the advantage of having been able to get answers from Gorham for a decade-and-a-half now, or more. If I have any additional questions, I will submit them for the record. I have already said my piece about Gorham.

Mr. STOKES. Mr. Chairman.

The CHAIRMAN. Yes, Congressman Stokes.

Mr. STOKES. Before we lose some more people in the audience to the noon hour, I would just ask for permission to be able to advise those in attendance here that this afternoon at 2 o'clock sharp, we will have Secretary Louis Sullivan here to address the Braintrust and other attenders of our joint hearings on the subject of: The Year 2000: National Health Goals.

I think that is going to be a particularly interesting and infomative speech by Secretary Sullivan. We would urge all of you, as you leave for the lunch hour after we conclude our morning hearings, to please try to be back by 2 p.m. sharp this afternoon.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Congressman Stokes.

We sincerely thank both of you gentleman and we really appreciate your contribution to the hearing this morning.

We will call our last panel at this time. I have just been notified that we are only a few minutes away, it appears, from a vote on the Senate floor.

Our last panel consists of: Mr. John Eason and Brian Abdul-Karim. Mr. Eason is from the Lee County Cooperative Health Care Center, Marianna, AR. Mr. Abdul-Karim is the Activities Outreach Coordinator, Greater Washington Chapter of the Alzheimer's Association, Bethesda, MD.

Let me say to our two witnesses that if there is a vote, I may have to leave in the middle of your testimony. Perhaps Congressman Stokes can stay just a few minutes longer.

Let me say a word about Mr. John Eason, if I might.

I whispered, John, to Congressman Stokes about an hour-and-a-half ago to ask: Do you see the gentleman out on the second row near the aisle? He said: Yes. I said: That gentleman's name is John Eason. He comes from one of the greatest poverty areas in America in the Delta of the State of Arkansas. I have known Mr. Eason for over 20 years. In spite of all the many problems that he sees every day, he is an eternal optimist.

I want to thank you, John, for coming all the way from Marianna, from the health clinic there that I visited at your invitation on several occasions. We look forward to your statement today. If I had been as smart as Senator Heinz, I would have given you a plaque, but I didn't think of it. [Laughter.]

Senator HEINZ. Mr. Chairman, you don't miss much.

The CHAIRMAN. Thank you, and John, we look forward to your statement.

## STATEMENT OF JOHN EASON, ADMINISTRATOR, LEE COUNTY COOPERATIVE HEALTH CARE CENTER, MARIANNA, AR

Mr. EASON. Thank you very much. Senator, Congressman Stokes, it is quite an honor for me to be here, and I bring greetings to you from the 15,539 people in Lee County, AR. The reason I do that is because if it had not been for gentlemen like you, we would not have been in business.

During the 1980's, one of our Presidents wanted to block grant all discretionary funds. If that had been done, we would not have been here. This is one way that we have of taking care of our poor.

At the Lee County Cooperative Clinic, we have about 10,000 users. Of that number, 8,000 are medical; 2,000 are dental. We use $41.07 per patient, and we see the people.

You were wondering, Senator, about a lot of people having six prescriptions. I have one here with 11. There was one man who came in with a Kroger sack full. He had 18, and we do have quite a few others in the same situation.

If the patient had to buy these prescriptions on the outside, it would have cost $212.43. We can let this patient have these same prescriptions for $44. The reason we can do this is because we do not have any waste at the Lee County Cooperative Clinic. We are only getting about half-a-million dollars more now than we were when I came there 13 years ago, sir. Many government programs have waste involved.

We are doing better management where you get more bang for your buck on the Federal dollar. Social Security—we have the elderly living on $281 per month Social Security. I was looking at CNN this morning, and they said that in Laredo, TX the per capita income was $16,300. If we in Lee County had $16,300 per capita, we would be rich.

It just goes to show you what we are trying to do. How do we do this? We do it by management. We have brought on staff a mechanic. We pay the mechanic $10,000. Where did we get the mechanic? We have vocational schools in Arkansas.

This young man graduated from vocational school. We use him as a driver and mechanic. We are trying to get as much for the grant dollar as we possibly can.

We also have a policy within the clinic that, if you leave the lights on, when you're not at your station we charge you a quarter. We don't leave lights on. If you went to the clinic right now, I would be willing to wage my month's salary that you may have one light on unnecessarily. That would be on the medical end. We don't badger the doctors because we are in an MUA, medically underserved area, and an HMSA, health manpower shortage area. We meet all of the discrepancies in our area. That is one of the problems we are having today.

Also, we have senior citizens. We work with the Area Agency on Aging. We have vans that go out to pick up the Seniors and bring them into the center once per week. We have five areas and we do it once per week for each area.

It is like when I was a boy going to town once per year at Christmas time. You are glad to see Christmas time, and these people are glad to see 1 day of the week that they can go to town. When they come to town, they do their shopping, pay their light bills, and they also go by the center and get a good meal.

A lot of our people in the county, gentlemen, only get one good meal per day, and that is the meal that they get at our senior citizens' center. We have 80 congregate meals and 80 home-delivered meals. Meals for the homebound people that cannot get out, are taken by drivers to them.

We also have a telephone system for the people that are shut-ins who cannot get out and come to town. What we do is call them and make sure that they are functioning well that particular day. If they are not, we send someone out to check on them.

What we are asking, in conclusion, is that you support the Federally Qualified Health Care Plan. That is S. 2538.

And Congressmen Stokes, we would like your support on H.R. 4233. That is to get full reimbursement on Medicare patients. In the printout, you will see that the clinic would get $97,000 in additional moneys. Therefore, we could serve 2,381 different people.

We are the eighth poorest county in the Nation. Think about the Founding Fathers. Thomas Jefferson said in 1776:

> We hold these truths to be self-evident: that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among them are life, liberty, and the pursuit of happiness.

The pursuit of happiness is very difficult when you are living on $281 per month.

Thank you.

The CHAIRMAN. Thank you, John. [Applause.]

[The prepared statement of Mr. Eason follows:]

LEE COUNTY COOPERATIVE CLINIC
530 West Atkins Blvd., Marianna, Arkansas 72360
(501) 295-5225

September 20, 1990

The Honorable David Pryor, Chairman
United States Senate
Special Committee on Aging
Room G31
Dirksen Senate Office Building
Washington, DC 20510-6400

Dear Senator Pryor:

We at the Lee County Cooperative Clinic support Federally Qualified Health Center (FQHC) cost based reimbursement for medicare.

This is what the new law would do for the Lee County Cooperative Clinic.

In 1989 we had some 10,000 users or different persons using the clinic. Of this 10,000 approximately 8,000 were medical. Twelve percent of these were medicare. As the law is now written for medicare there is a $75 deductible, therefore a medical user comes to the clinic two (2) times before we collect anything for him. We are now billing medicare $39.00 and they are paying 80% which is $31.20. The actual cost of seeing a patient at the clinic is $41.07.

The grant from HHS is subsidizing medicare clients in the amount of $9.87 per visit.

The average medicare user averages 4 visits per year to the clinic. If the new law were passed Lee County Cooperative Clinic would receive an additional $97,805. Therefore, we could average an additional 2,381 encounters or visits.

Even though we are not very proud of this fact, we are still the eighth poorest county in the nation. This puts a great economic burden on our patients. Medical care is in most cases the last thing that they seek.

The needs of the elderly population of America are basically the same, whether they are ethnic or otherwise. Perhaps the only major difference manifests itself in the economic status of these older Americans. The ethnic elderly, even the ones who have worked for many years and retired, often find themselves in an economic bind. They can not afford the medical care required, socialization, transportation, food, clothing or shelter needed to live an independent life.

CARES

AN EQUAL OPPORTUNITY EMPLOYER

Once the ethnic elderly pass the age of 60, all kinds of health problems attack them. They are plagued by hypertension, diabetes, arthritis, heart disease, and various breathing problems. Obviously, it doesn't take long to wipe out their finances with medication and other medical bills incurred. It is much easier for them to find someone to help them in the socialization process, provide transportation for them to go and pay their bills, go to the Beauty or Barber Shop, and buy groceries than it is for them to meet their medical needs. This is why it is imperative that the medicare program be updated and improved. Our elderly need to be cared for and helped to live independently. If institutionalization is the only answer for them, they will still have a better life if they are able to pay for this care.

When you see Black Americans crippled by arthritis and can bearly move around, or overcome by attacks of hypertension and diabetes and cannot afford to buy the medicine, or just incapacitated by heart disease, infections and other medical problems, and you realize how much quality time they have given to the growth and development of our country, you become extremely depressed. You are depressed because you know that there must be ways of helping these Older Americans to live in dignity and to be comfortable. You also wonder about yourself because you know that in a few years that Older American is going to be you. What then?

We would be appreciative of any help that we could get in Lee County and the Mississippi Delta.

OLD LAW

12% Medicare Users = 960 users
2 visits X 960 = 1,920 visits
1,920 visits X 0 = 0 dollars
2 visits X 960 users = 1,920 medicare encounters or visits
Billing medicare $39.00 X 80% = $31.20
$31.20 X 1,920 = 59,904

PROPOSED FQHC COST BASED REIMBURSEMENT

12% medicare users X 8,000 = 960 users
960 users X 4 visits = 3,850 visits
3,840 X $41.07 (cost) = 157,709

| | |
|---|---|
| **Proposed Law** | $157,709 |
| **Old Law** | 59,904 |
| **Difference** | $ 97,805 |

$97,805 ÷ $41.07 = 2,381.

Sincerely,

John A. Eason

John A. Eason
Administrator

The CHAIRMAN. We will put the entirety of your statement into the record, John, but I am sure we cannot give it the same flavor in print that you gave to it orally. We appreciate that.

Mr. Abdul-Karim.

**STATEMENT OF BRIAN ABDUL-KARIM, ACTIVITIES OUTREACH DIRECTOR, GREATER WASHINGTON CHAPTER, ALZHEIMER'S ASSOCIATION, BETHESDA, MD**

Mr. ABDUL-KARIM. Good morning. Chairman Pryor and Congressman Stokes, on behalf of the Alzheimer's Association, it is really an honor and privilege for me to be here to share with you this morning.

As we all know, our society is changing rapidly. Not only is it graying, becoming older, but the color of our society is changing as well. The people that we are talking about today are basically in double jeopardy. They carry the burden of being persons of color in America and they also carry the stigma of age and the stereotypes that our society has about that.

As our society is changing as it relates to health care, we are finding a shift from the authoritarian expertise role of physicians to the role of the patients becoming consumers. The change that we are pointing to here is that adults want to be informed so that they can make decisions and control their own destiny. We see that in basically every field of influence in our society.

As adult ourselves, I think that one of the critical questions this boils down to is: As adults, we are all either in the role of learner or in the role of educator. Whatever profession we are in, we are challenged to help adults learn how to learn so that they can meet the demands of the changing society and survive.

As an employee of the Alzheimer's Association, I am aware of the need of the general public to learn about Alzheimer's disease. We looked at some charts we have here, and we recognize that Alzheimer's disease is considered by many and by us as the fourth leading cause of death among people 65 and over. We have approximately 130,000 people per year dying from Alzheimer's disease.

Now that may not be what is on the death certificate because it may be that pneumonia developed or infection from bedsores or other things, but we attribute it directly to Alzheimer's disease. So it is a process of education, and we are competing with all these other issues. That is our issue.

If the goal of learning is to change behavior in some way to improve life, then I think a critical issue here is to provide the black elderly with information. Of course, that becomes difficult because we have found that traditional methods do not work. Basically, they don't respond to formal educational systems.

I have outlined an example, which I think is a very dramatic example, of the black elderly's need for information. It is a classic story of a woman I met who, for 8 years, had cared for her husband with Alzheimer's disease without knowing that he had Alzheimer's disease. I am talking about 8 years.

She depended on a general physician to inform her and help her, and he did not do that because he didn't know. That is a lack of information, and that is one of the most critical needs.

We have found in our experience that you have to take the information to the people. If folks do not respond to formal educational settings—and it is historically our tradition that we respond to nonformal educational settings—then you take the information there, to the churches, to the civic associations, to the community organizations, and utilize African-American media, which is an instrument for getting information to people.

Second, we suggest that the services have to be set up in the neighborhoods where African-American elderly live, and they have to be staffed by people of similar ethnic backgrounds. One of the things is that folks tend to respond to people that they trust or that have been recommended by somebody they trust or where there is some sense of family connection. This is very important.

We believe that the black elderly's children and other family members must also be educated about the issues, concerns, and solutions. We are all caught in the sandwich generation, caring for older parents and young children, so they need to be educated.

The service providers need training on the values, the needs, and the interests of the minority elderly and training to develop a sensitivity to the needs of the black elderly and, I believe, training to develop the qualities to do outreach, because it takes certain qualities, personal skills and other things, to be effective in helping that older person to learn to change their behavior so that they can benefit.

We also suggest that there be a conscious effort on the part of all organizations to recruit more African-Americans to serve on the decisionmaking boards, commissions, and so forth, people who are actually committed to outreach. All African-American people are not committed to outreach, and it takes people who are committed to that to help with the decisionmaking processes.

As I listened to the talk about research today—you know there has been a lot of research and statistics and this is the problem and this is the disparity and so forth. I would offer a suggestion, a more humanistic approach. Do some research asking the black elderly: what are the solutions to the problems you have? Quite often, the solution we have lies within ourselves because of experiences.

I would like to just end my testimony with a short story. It is about a leader of a country far away from here. It is very, very old, having been passed down for many generations and many centuries.

Basically, there was an elderly man in the society whose needs were not being met. The people talked about it, and when this leader found out about it, he was furious. He said: this is a shame and is not fair. This man has worked his whole life and contributed to the society. Yet, when he gets older, we have neglected his needs. So he immediately did something to give some help to the man's needs.

I recognize this story with this group in the fact that you set this up and you are here. I am singing to the choir in a sense, but I think that this story does point to an attitude that has to be developed in our general culture, in our society, among all of us who are leaders in some respect and among the general society, to respond to the needs we are challenged to change so that we respond to the

needs of the black elderly and help solve the problems they are faced with.

Thank you very much for this honor.

[The prepared statement of Mr. Abdul-Karim follows:]

Hearing before the Senate Special Committee on Aging
"Profiles in Aging America:
Meeting the Health Care Needs of Our Nation's Black Elderly"
Friday, September 28, 1990

Testimony by Brian Abdul-Karim, Alzheimer's Association

The Alzheimer's Association is a non-profit voluntary organization that started in 1979. Today, it has grown to over 200 chapters throughout the United States. In 1988, the Alzheimer's Association of Greater Washington, a local chapter serving Washington, D.C., Montgomery and Prince Georges Counties, began its minority outreach efforts. This endeavor was undertaken because of the commitment of the organization's leadership to meet unmet needs. Major factors in getting started were committing the resources necessary to hire a staff person to perform this function and negotiating office space at the Shiloh Family Life Center, a stable, influential, credible, highly recognized and respected African-American church with a 125 year history of service to the community.

STRATEGY AND APPROACH

Our approach and strategy has been simple. First, to cultivate relationships with individuals and institutions in the city, and second, to be available to respond to their needs.

We began this process by cultivating relationships with workers and the leadership at the Shiloh Family Life Center. The goal was to earn respect and trust and to be considered as part of the "family," thereby, able to receive their support and access to their network. We found that trust is earned by being dependable and responsive and by seeking assistance from others.

The same process was used to build working relationships with local African-American educational institutions (Howard University, University of the District of Columbia), African-American churches, community organizations, non-profit organizations, local government agencies, and African-American media.

Through the process of developing these relationships and listening to people, we began to identify two dominant areas of need: the need for correct information and the need for support.

There are two experiences that best describe these needs. In 1988, I met a woman who had cared for her husband for eight (8) years before she found he had Alzheimer's disease. During that period she took him back and forth to her doctor, a general

practitioner and never did he diagnose. Finally, after 8 years, the man got violent and she took him to the Veterans Administration Hospital where they did a diagnostic work up and diagnosed him as having Alzheimer's disease.

This woman suffered silently for eight years while living in a nightmare because of lack of information. The general physicians are implicated as a group needing correct information on Alzheimer's disease. I have heard many stories from caregivers

where doctors did not know enough about Alzheimer's disease to direct the family or help them learn how to cope. Over and over again, I have heard that saw strange behaviors, sometimes for years, prior to diagnosis, but didn't know what they were seeing because they didn't know about the disease.

The second experience that points out people's need for support was when I met a woman whose mother had died of Alzheimer's disease 3 1/2 years prior. I spent 45 minutes listening to this lady as she questioned and wrestled with all the emotions and feelings that were still so deep and strong within her from the tragic experience of caring for her mother and the problems it caused within her family.

It became apparent to me that this woman had not finished grieving for her mother after 3 1/2 years. This experienced affirmed for me the fact that caring for a loved one with Alzheimer's disease is an "endless funeral" before death and, in this case, after death.

Although these two examples may seem extreme, I began to see people's need for correct information and support in many ways, such as: jokes people make about having Alzheimer's disease, anxiety of caregiver in a crisis situation, ignorance of general public about facts related to Alzheimer's, misconceptions about old age, senility, and memory loss, etc.

We found that minorities need information to help them deal with false perceptions, and feelings of fear, shame, embarrassment, and denial. Furthermore, they need information to understand the disease, such as: symptoms, stages of the disease, and diagnosis procedures. They need information on the physical, mental, emotional and financial impacts of the disease on the family. They need to learn coping techniques and support to help them balance their emotions in these difficult situations.

Lastly, they need information on and referral to appropriate support services available in the community. Of course, this is sometimes a greater need for minorities because quite often support services are not located in their neighborhoods and access is limited. Also, if services are not rendered by someone of similar racial and ethnic background, with the proper sensitivities, then it becomes more difficult for minority persons to wan to utilize the service.

ACCOMPLISHMENTS

In an attempt to respond to these needs, the Alzheimer's Association of Greater Washington has been able to make certain accomplishments, which are listed below.

* Operate a D.C. Satellite Office at the Shiloh Family Life Center, 1510 9th Street, N.W., Washington, D.C. 20009, (202) 483-4258.

* Two of the last three Annual Caregivers Conferences have been held in Washington, D.C. and we have seen a slight increase in the number of minority participants.

* Five public community education programs per year are sponsored by the Association in neighborhoods highly populated with African-Americans and other minorities.

* Sponsored a Clergy Conference for churches in Washington, D.C. which was attended by 70 persons, most of which were African-Americans.

* Worked with Howard University's WHMM-TV on production of a documentary, on Alzheimer's disease and African-Americans to be aired on October 11th and 14th at 8 p.m. on Channel 32.

* Completing a minority oriented brochure with a brief overview of Alzheimer's disease and a list of community services within the city.

* Receiving a steadily increasing number of calls from African-Americans for information and referral services.

* Increased visibility of Association's services through appearances on African-American television and radio programs.

* Started three family caregiver support groups in predominantly African-American neighborhoods.

* Recruited African-Americans for the local chapter's Board of Directors and Committees.

* Given numerous presentations at churches, community organizations, civic associations, non-profit organizations and government agencies.

Even with these accomplishments, we are only scratching the surface in relation to the numbers of minorities in need and the types of programmatic responses that can be developed.

RECOMMENDATIONS

1. Ensure adequate representation of African-American persons on organizational decision making groups such as the Board of Directors, Commissions, and Special Committees. Adequate representation is a number that reflects the proportion or percentage of African-Americans living in the geographic service area. Token numbers of minority representatives will not suffice.

2. Hire more minority persons to engage in outreach activities to educate and increase awareness of the minority population on health care issues affecting the minority elderly.

3. Locate more support services in minority neighborhoods and develop long-range plans and strategies for effective service delivery.

4. Develop more educational materials relevant to experiences and concerns of minorities. Pictures of minority persons do not necessarily make the materials relevant.

5. Train service delivery staff to increase their sensitivity to the special needs of minority elderly and more effective methods of service delivery.

Thank you for the opportunity to share.

Brian Abdul-Karim

The CHAIRMAN. Thank you very much. That was a strong statement. [Applause.]

That was a fine statement, Mr. Abdul-Karim.

Talking about some of these changes, I cannot help, Congressman Stokes, to reflect about some changes I have seen in 20 years. I go back once again to Mr. John Eason, and I can remember, John, 20 years ago, attempting to establish the Lee County Medical Clinic to serve the various poorest of the poor. It tore that county half in two because of the controversial aspect of this public health clinic.

But I will tell you that today it is different. If you tried to close the doors of the Lee County Medical Clinic, about 98 percent of that county would be up in arms. Today, there has been an acceptance and an acceptability and public support, but it has taken a long time.

We have seen some change, but that change is not universal enough. It is not forthcoming and it is not fast enough, but I remember those days and it was not easy.

Did you want to comment on that?

Mr. EASON. The only thing I wanted to comment on is that it is not only Lee County. We have people coming from as far away as Blytheville. It is Phillips County, Lee County, and the surrounding areas.

One of the people I was talking about was from Helena. We had one family coming from Mountain Home, Senator, which is 153 miles one way. They would get to the clinic—I usually get there at 7 a.m., and they would be there.

The CHAIRMAN. That is a great story.

Congressman Stokes.

Mr. STOKES. Mr. Chairman, I don't think I have any questions. I just want to make a couple of comments if I may.

Mr. Abdul-Karim, in your recommendations there were two that stand out particularly in my mind. I am glad to see that you have resorted to these two. One was where you mentioned sponsoring a clergy conference for the churches in Washington.

All of us know that in the black community, the black church has a very special role in terms of its community and has always sort of interceded as an intermediary in bringing information to its people. I see you have utilized that mechanism, and you are to be congratulated for that.

Then the other one is where you started three family caregiver support groups in predominantly African-American neighborhoods. As you heard me comment earlier today when one of the panels was on, traditionally and historically in the black community, females in the black community tend to be the ones who give the care to their elderly and they try to give it to them in the home as opposed to in institutions. They try to care for our elderly right there in the home.

So I see that you are resorting to that type of caregiver support, and I think that is so very important.

Mr. ABDUL-KARIM. Thank you very much.

Mr. STOKES. Mr. Eason, I guess that all I can say is that every county ought to have a John Eason. [Applause.]

Any time that Senator Pryor and people in Arkansas don't treat you right, you can always come to Cleveland. [Laughter.]

I know from the type of things he said to me that you are one of their prized jewels and assets there. He talked so glowingly to me privately about what you have meant to the people that you serve there in Arkansas. We are indeed privileged and honored that you have taken time out to come here and share with us this enriching experience.

I just want to say to both of you that we are indeed appreciative of your appearance here today.

The CHAIRMAN. Congressman Stokes, John Eason has been offered three and four times what he is making in salary, in several other States and several other occupations, but he as turned those lucrative offers down. He says he wants to remain with his people.

I admire you for that, John.

Mr. EASON. Thank you, Senator. [Applause.]

Mr. STOKES. Mr. Chairman, before we conclude may I once again express my appreciation to you, not only on my own behalf, but on behalf of the Congressional Black Caucus Health Braintrust, the ladies and gentlemen that you have seen in this room where we have had such a tremendous outpouring of attendance this morning, and the people who come to Washington, DC, sometimes two or three times each year at their own expense to share with me the kind of expertise they possess in the area of health.

As you know, you and I are legislators, not health experts, but these people give us the kind of expertise we need in order to legislate in the area of health. You have done such a magnificent job in this area here on the Senate side. It has been an honor to work with you in the House, on the Pepper Commission, and here this morning for these great hearings. I just want to thank you again.

The CHAIRMAN. Congressman Stokes, thank you. [Applause.]

I will conclude by also saying what an outstanding hearing I think this is: the testimony that we have gathered, the witnesses who have come to enlighten us, not only on statistics but with factual data, and all of these things.

I will conclude, Congressman Stokes, by saying that if we do not do anything with these statistics; if we do not do anything with this information; if all we do is sit up here and listen and close down the hearing and go off and do something else, then we have failed in our job, and I hope we do not fail. [Applause.]

Thank you all very much.

[Whereupon, at 12:48 p.m., the Committee was adjourned, to reconvene at the call of the Chair.]

# APPENDIX

Item 1

STATE OF ILLINOIS

DEPARTMENT OF AGING

"PROFILES IN AGING AMERICA: MEETING THE HEALTH CARE NEEDS OF OUR NATION'S BLACK ELDERLY

**Health care for older black women: an unaffordable luxury**

Thank you for inviting me to participate in this hearing on an issue of vital social importance. My name is Carol Jones, and I serve as special assistant to the director of the Illinois Department on Aging, as well as a member of the national board of the National Caucus and Center on Black Aged.

Addressing the health care needs of older black women has been a priority of the Illinois Department on Aging for the past five years. Though we have heard through the media an awful lot about the wealth of the mature market, there are deep pockets of abject poverty, especially among older minority women. In fact, there are four characteristics that increase your likelihood of being abysmally poor: • if you are a woman, • if you are a minority, • if you are 85 and older, • or if you live alone. If you fit *all four* of these categories — if you are an elderly black women who lives on her own — you face a quadruple jeopardy of impoverishment ... and your health care becomes an unaffordable luxury.

More women of all races survive to old age than their male counterparts, so they face greater health problems and are more likely to suffer multiple, long term chronic illnesses, sensory losses, arthritis and diabetes. Additionally, black women older than 65 have the highest risk of hypertension of any other group in the country: One in three blacks has high blood pressure. Black women also have a 100 percent higher rate of diabetes than white women, and the resulting complications — heart disease, stroke, kidney failure and blindness — occur more frequently to blacks. What's more, the rates of death among blacks from cirrhosis of the liver, esophageal cancer and lung cancer are dramatically higher than for whites. And the average life expectancy of blacks is 69.6 years, five years shorter than for non-minorities.

Health care is an expensive commodity, and older people make up a hefty portion of the health expenditure pie: People older than 65 account for one-quarter of all health care dollars spent in the United States; they occupy more than 40 percent of all hospital beds on any given day; they take 25 percent of all prescription and over-the-counter medications; and they spend an average of $1,500 out of their pockets each year for health care.

When you combine the overwhelming and costly health care needs of older adults with the plight of many older black women, the implications are profound and unsettling.

With limited resources and extensive health needs, it can be very difficult to grow

old. But to grow older as a black women is even more difficult. In fact, the National Caucus and Center on Black Aged reports that in 1983, 42 percent of older black women were living in poverty, and 65 percent of older black women who lived alone or with non-relatives were living in poverty. In today's dollars that means an annual income of $6,280 for a single person and $8,420 for a married couple, or $523 to $701 a month.

But when you compare the poverty levels of older black women with the overall rate for older women, the disparity becomes cruelly clear. Thirty-four percent of all older black women are in poverty, as compared with 14 percent of all older women.

But the picture gets bleaker. The annual incomes of older black women are appallingly meager: The most recent data indicates that the median income of black women older than 65 in Illinois is a mere $3,088. That is less than $260 a month for the average older black woman in our state to cover housing, food and basic necessities, which leaves scarce resources for skyrocketing health care costs. Additionally, many older women living below the poverty level are not eligible for Medicaid without significant spend down of their incomes.

Long term care is also an issue that significantly impacts on older women in general, but especially on older black women. Why? Women live longer than men, thus their health care needs are extended; middle-aged women are the most likely to be the primary caregivers to the frail elderly in need of long term care; more than 70 percent of nursing home residents are women; older women are more likely to be single and live alone than men, lacking the family support that might make it possible to remain in their homes; and, finally, their income levels are just about half that of men, 56 percent. Even when existing services are available to help older black women, they frequently are not aware of them or they do not know how to access them.

The Illinois Department on Aging has focused on the health care needs of older adults through its Community Care Program, an in-home care program administered with Older Americans Act funding to keep the frail elderly in their own homes as long as possible. The majority of Community Care clients are older than 75, fully 81 percent are women and 36 percent are black.

The needs of older women, particularly minorities, have been a major concern of the Department on Aging since 1985, when it — together with the Council on Aging — formed the Task Force on the Status of Older Women in Illinois to learn more about older women, to raise their concerns of older women and make recommendations. A series of 23 hearings and roundtables brought together more than 1,300 older women statewide from December 1985 to April 1986. The task force report, which was published in November 1986, addressed the three major issues which emerged from the hearings: income, health and housing. In August 1990, the Department released an update of the original report; both reports include data that show how dramatically different and severe the needs of older black women are.

Additionally, in July 1990, the Department released a comprehensive report on the issues of significance to older adults for the 1990s, with specific chapters devoted to both health care issues and special-needs populations. We also work through organizations such as the American Association of Retired Persons and its minority task force to advocate on behalf of older black women and to provide community outreach.

But it is still not enough.

Clearly, the plight of older black women is foremost in the minds of Illinois officials, and the State is doing its very best to address these needs. But funding is stretched to the limit, and the elderly black woman is frequently the one who suffers.

She needs increased funding for more and better health care services. Today, the older black woman's needs *are not* being met. And sadly, health care has become a luxury beyond her grasp.

Item 2

**HEALTH STATUS OF AGED BLACKS**

**NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.**

## I. Introduction

Older Blacks have poorer health than aged Whites by numerous standards of measurement. In many respects, a health care crisis afflicts hundreds of thousands of Blacks 65 years of age or older. It takes numerous forms, and it is expressed in many ways.

Nearly one out of every two (48.2 percent) Blacks 65 or older rated their health as poor or just fair in 1988. In marked contrast, only about one out of every four (27.7 percent) elderly Whites considered their health to be poor or fair in 1988.

At the other extreme, aged Whites are much more likely to have a positive perception about their health status. In 1988, 39.0 percent of all Whites 65 or older regarded their health as excellent or very good, compared to only 25.4 percent for aged Blacks.

**Perception of Health Among Persons 65 Years of Age or Older in 1988**

| | All Races | White | Black |
|---|---|---|---|
| Excellent | 16.3% | 17.0% | 9.0% |
| Very good | 21.5 | 22.0 | 16.4 |
| Good | 32.8 | 33.3 | 26.4 |
| Fair | 19.9 | 19.1 | 29.3 |
| Poor | 9.5 | 8.6 | 18.9 |

**Source:**
"Current Estimates From the National Health Interview Survey, 1988", U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics, Series 10, No. 173, Oct. 1989, p. 114.

The perception of poorer health among older Blacks is supported statistically by numerous indices. For example, the average number of bed days associated with acute and chronic conditions is 55.1 percent greater among aged Blacks than elderly Whites: 21.4 days vs. 13.8 days.

**Average Number of Bed Days Associated With Acute and Chronic Conditions for Persons 65 or Older**

| | All Races | White | Black |
|---|---|---|---|
| Total persons | 28,683,000 | 25,817,000 | 2,401,000 |
| Total bed days | 412,094,000 | 355,233,000 | 51,345,000 |
| Average bed days during year | 14.4 | 13.8 | 21.4 |

**Source:**
Unpublished data from the National Health Interview Survey, 1988, U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Controls, National Center for Health Statistics.

Elderly Blacks are also less likely than aged Whites to have no bed days during the preceding year. In 1988, about three out of five (59.4 percent) Blacks 65 years of age or older had no bed days during the preceding twelve months, compared to two out of three (66.2 percent) aged Whites.

**Persons 65 Years of Age or Older With No Bed Days During the Preceding 12 Months**

| | All Races | White | Black |
|---|---|---|---|
| Total persons | 28,683,000 | 25,817,000 | 2,401,000 |
| Without bed days | 18,837,000 | 17,102,000 | 1,426,000 |
| Percent without bed days | 65.7% | 66.2% | 59.4% |

**Source:**
Unpublished data from the National Health Interview Survey, 1988, U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Controls, National Center for Health Statistics.

The purpose of this paper is to analyze both qualitatively and quantitatively the health status of aged and aging Blacks from four key perspectives:

1. Epidemiology and mortality;
2. Affordability;
3. Access; and
4. Long-term care.

## II. Epidemiology and Mortality

A racial health gap exists between Blacks and Whites in our society today. Haynes Rice, director of Howard University Hospital, said, "We've made some improvements overall, but we haven't closed the gap between Black and White." [1]

Perhaps the most visible manifestation of this phenomenon is the significantly shorter life expectancy for Blacks than Whites. Life expectancy at birth in 1987 was 5.3 years longer for White females than Black females: 78.9 years vs. 73.6 years. The differential was 7.0 years for males. Life expectancy for White males was 72.2 years, in contrast to 65.2 years for Black males.

Blacks also have a shorter life expectancy at ages 45 and 65 than Whites. In fact, Whites can typically expect to live, on the average, 9 to 11 percent longer than Blacks at various ages.

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[1] "The Black White Health Gap", Don Colburn, Washington Post, Health Section, April 5, 1988, p.1.

**Life Expectancy for Black and Whites in 1987**

| Age | Black | white | Percentage Longer For White Than Blacks |
|---|---|---|---|
| At Birth | | | |
| Males | 65.2 | 72.2 | 10.7% |
| Females | 73.6 | 78.9 | 7.2% |
| Age 45 | | | |
| Males | 26.6 | 30.6 | 15.0% |
| Females | 32.3 | 35.9 | 11.1% |
| Age 65 | | | |
| Males | 13.5 | 14.9 | 10.4% |
| Females | 17.1 | 18.8 | 9.9% |

**Source:**
Unpublished Final Data, Dept. of Health and Human Services, Public Health Service, Division of Vital Statistics.

A mortality crossover does occur at more advanced ages. Some experts have theorized that this is an application of the survival of the fittest principle because Blacks who live into their 90's and beyond are an especially hardy breed since they have been able to survive despite withstanding much adversity.

However, the significant differences in life expectancy between Blacks and Whites provide powerful evidence that a major health gap exists in our nation. This gap has persisted, and in some cases widened for numerous relevant health barometers.

In fact, the health status for Blacks is appreciably below that for Whites at practically all ages under numerous relevant standards of measurement. This point was made emphatically in the 1986 Health and Human Services "Report of the Secretary's Task Force on Black & Minority Health".

The Task Force analyzed both life expectancy and the "excess death rate" (basically the number of deaths for Blacks compared to the number that would have occurred if the Black death rate for each age and sex was the same as for the White population) to provide benchmarks for analyzing this situation.

The Task Force found that there were nearly 60,000 "excess deaths" per year for Blacks. Approximately four out of every five excess deaths among minorities (the vast majority of whom were Blacks) resulted from six causes: (1) cancer, (2) heart disease and stroke, (3) infant mortality, (4) diabetes, (5) homicide and unintentional injuries, and (6) chemical dependency (primarily alcohol abuse as revealed by cirrhosis). Cancer, heart disease and stroke were leading causes of "excess deaths" among older Blacks, especially when deaths up to age 70 were analyzed.

## Stroke

Limited morbidity and mortality information is available about aged and aging Blacks in the Secretary's Task Force Report on Black and Minority Health. The Task Force found aged Blacks have a much higher death rate from strokes than elderly Whites. For example, the stroke mortality rate was 3.8 times as great for Black males 45 to 54 years old as for White males in the same age group and 2.0 times as great for Black males 65 to 74 years old as for White males in the same age bracket. However, the stroke death rate for Black males 85 or older is less than it is for White males in the 85-plus age group. This may be another application of the so-called "survival of the fittest" principle for older Blacks.

A similar trend exists for elderly Black females. Their death rate from stroke is 2 to 3 times as great as elderly White females from ages 45 to 74. It is 1.3 times as great for those 75 to 84 years and slightly below that for Black females 85-plus than the stroke death rate is for White females in the same age bracket.

**Ratio of Stroke Mortality by Age, 1980: Black and White**

| Age | Black Males/White Males | Black Females/White Females |
|---|---|---|
| 25-34 | 3.5 | 3.5 |
| 35-44 | 4.5 | 3.2 |
| 45-54 | 3.8 | 3.3 |
| 55-64 | 3.0 | 2.8 |
| 65-74 | 2.0 | 2.1 |
| 75-84 | 1.1 | 1.3 |
| 85+ | 0.8 | 0.8 |
| Total | 1.8 | 1.8 |

**Note:** If the relative death rate is greater than 1.0, the rate is proportionately greater for Blacks than Whites. A value of 1.0 indicates that the Black death rate is the same as the White death rate. A value less than 1.0 shows that the death rate for Black is less than for Whites.

**Source:**
"Report of the Secretary's Task Force on Black and Minority Health, Volume IV: Cardiovascular and Cerebrovascular Disease, Part I", U.S. Dept. of Health and Human Services, January, 1986, p. 106.

## Heart Diseases

Death rates for coronary heart disease are lower for Black males 65 or older than for White males in the same age bracket. The death rate is exactly the same for both Black males and White males 55 to 64 years old. It is slightly higher, though, for Black males 45 to 54 years old.

Black females have a noticeably higher death rate from coronary heart disease than White females from age 45 to 64, a slightly higher death rate from age 65 to 74, and a lower death rate at age 75 or older.

**Black/White Ratios of Death Rates for Coronary Heart Disease, 1980**

| Age | Black Males/White Males | Black Females/White Females |
|---|---|---|
| 25-34 | 2.28 | 3.30 |
| 35-44 | 1.45 | 2.90 |
| 45-54 | 1.19 | 2.28 |
| 55-64 | 1.00 | 1.78 |
| 65-74 | 0.84 | 1.22 |
| 75-84 | 0.75 | 0.90 |
| 85+ | 0.64 | 0.65 |

**Source:**
"Report of the Secretary's Task Force on Black and Minority Health, Volume IV: Cardiovascular and Cerebrovascular Disease, Part I", U.S. Dept. of Health and Human Services, Jan. 1986, p. 97.

The death rate from acute myocardial infarction is lower for middle-aged and older Black males than for White males. At ages 45 to 54, the death rate is essentially the same for both groups. However, the rate starts to decline steadily at ages 55 to 64 until it is significantly lower for Black males 85 or older (64 percent of the death rate for White males).

A different pattern exists for middle-aged and older Black females. Their death rate from acute myocardial infarction is more than twice as great as it is for White females at ages 45 to 54. Then, it drops steadily until the death rate is nearly the same at age 65 to 74. Thereafter, it continues to fall so that the death rate from acute myocardial infarction for Black females 85 or older is 72 percent of that for White females in the same age group.

**Black/White Ratios of Death Rates for Acute Myocardial Infarction, 1980**

| Age | Black Males/White Males | Black Females/White Females |
|---|---|---|
| 25-34 | 2.00 | 3.28 |
| 35-44 | 1.28 | 2.70 |
| 45-54 | 0.98 | 2.02 |
| 55-64 | 0.84 | 1.54 |
| 65-74 | 0.71 | 1.07 |
| 75-84 | 0.66 | 0.84 |
| 85+ | 0.64 | 0.72 |

**Source:**
"Report of the Secretary's Task Force on Black and Minority Health, Volume IV: Cardiovascular and Cerebrovascular Disease, part I", U.S. Dept. of Health and Human Services, Jan. 1986, p. 97.

The Black/White death rate for other coronary heart diseases is substantially higher for Black males at ages 45 to 54, significantly higher for Black males 55 to 64, slightly higher for Black males 65 to 74, and lower for Black males after age 75.

Black females have a death rate from other coronary heart diseases that is 2 to 3 times as great as for White females in the 45 to 64 age bracket. It is nearly 1.5 times as great for Black females 65 to 74 years old. After age 75, White females have higher death rates from other coronary heart disease than Black females.

**Black/White Ratios of Death Rates for Other Coronary Heart Diseases, 1980**

| Age | Black Males/White Males | Black Females/White Females |
|---|---|---|
| 25-34 | 2.81 | 3.33 |
| 35-44 | 1.82 | 3.27 |
| 45-54 | 1.66 | 2.83 |
| 55-64 | 1.34 | 2.22 |
| 65-74 | 1.04 | 1.46 |
| 75-84 | 0.84 | 0.95 |
| 85+ | 0.63 | 0.62 |

Source:
"Report of the Secretary's Task Force on Black and Minority Health, Volume IV: Cardiovascular and Cerebrovascular Disease, Part I", U.S. Dept. of Health and Human Services, Jan. 1986. p. 97.

The Task Force debunked several myths about coronary heart disease and its impact on Blacks. For example, there is a widely held belief that coronary heart disease (CHD) is uncommon among Blacks. However, CHD is the leading cause of death among Black males and females 65 years of age or older.

**Proportionate Mortality for Coronary Heart Disease (CHD) for Black Males and Females in the U.S., 1980**

| | Males | | | Females | | |
|---|---|---|---|---|---|---|
| Age | Deaths All Causes | Deaths CHD | Percent CHD | Deaths All Causes | Deaths CHD | Percent CHD |
| 65-74 | 29,095 | 6,561 | 22.6% | 23,728 | 5,662 | 23.9% |
| 75-84 | 21,046 | 5,172 | 24.6% | 22,371 | 6,031 | 27.0% |
| 85+ | 8,534 | 2,373 | 27.8% | 13,115 | 3,767 | 28.7% |

Source:
"Report of the Secretary's Task Force on Black and Minority Health, Volume IV: Cardiovascular and Cerebrovascular Disease, Part I", U.S. Dept. of Health and Human Services, Jan. 1986, p. 98.

**Cancer**

The Task Force report does not provide much specific information about the incidence of cancer for aged and aging Blacks. Nearly all of the data relate to cancer morbidity and mortality among Blacks of all ages, both young and old.

The Task Force found that Blacks have the highest cancer incidence and cancer mortality of any population group in the U.S.

> Blacks experience greater incidence rates than non-minorities for cancers of the esophagus, pancreas, stomach, cervix, prostrate, and larynx. Excess mortality exists for cancers of the following sites: esophagus, stomach, lung, cervix, corpus uteri, bladder, and prostrate. Poorer survival occurs for many cancers and is marked for cancer of the breast, corpus uteri, bladder, prostrate, and rectum. Excess incidence and mortality is particularly pronounced among Black males. [2]

Blacks had a 10-percent excess incidence of cancer compared to non-minority Americans for the period 1973 to 1981. The incidence rate was 25 percent higher for Black males than non-minority males. However, the overall cancer rate for Black females was 4 percent lower than for non-minority females. [3]

Environmental and occupational reasons contribute significantly to the higher incidence rate of cancer among Blacks than non-minorities. Blacks have often been exposed to greater carcinogenic agents in the work force than non-minorities. They have been disproportionately represented in unskilled occupations which often have greater risks to carcinogenic agents (e.g., asbestos, polycyclic hydrocarbons, and others). A good example is Black workers assigned to coke ovens in the steel industry. Additionally, the large migration of Blacks from the rural South to the urban North during the 1930's, 1940's, and 1950's increased exposure to environmental risks and factors now known to be closely connected with the incidence of cancer.[4] Smoking is also more prevalent among Blacks than non-minorities. Smoking is, of course, a leading cause of lung cancer. Experts believe that this is a key reason that Black males have a 45 percent excess death rate from lung cancer than non-minority males.[5]

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[2] "Report of the Secretary's Task Force on Black and Minority Health, Volume III: Cancer", U.S. Dept. of Health and Human Services, Jan. 1986: p. 20.

[3] Ibid at p. 13.

[4] Id at p. 14.

[5] Id at p. 14.

The 5-year survival rate for the period 1976 to 1981 was significantly lower for Blacks than for non-minorities: 38 percent vs. 50 percent.[6] Several factors are attributed to the lower survival rate for Blacks than non-minorities. These include lateness in diagnosis, delays in detection and treatment, and general knowledge about cancer warnings. For example, Blacks are generally less knowledgeable about cancer warnings than non-minorities. The report notes that Blacks are less likely than non-minorities to see a physician to report cancer symptoms.

The survival gap is not based on race or ethnic origin, according to the Task Force. Rather, it is closely linked to socioeconomic status, especially the high incidence of poverty among Blacks in the U.S. which often affects the ability of Blacks to obtain timely and quality health care. When adjustments are made for stages of diagnosis, the survival rate decreases for certain cancers between Blacks and non-minorities. The difference in the survival rate is further reduced when adjustments for socioeconomic status are made.[7]

The report had tables which compared mortality rates for age-specific cancers for older Black and non-minority males and females. Key findings for the period 1978-81 include:

Black and Non-Minority Males Aged 50 and Above

Colon and Rectal Cancer: Black males have a higher mortality rate from these forms of cancers from age 50 to 60. From age 60 to 70, the mortality rate for Black males and non-minority males is essentially the same. Thereafter, non-minority males have a higher mortality rate, which becomes more pronounced at age 80 and much greater at age 85 and above.[8]

Esophageal Cancer: Black males have a sharply higher mortality rate from esophageal cancer than non-minority males from age 50 and beyond. The gap narrows at age 70, but the mortality rate ranges from about two-thirds to more than twice as great for Black males 70 or older than elderly non-minority males in the same age bracket.[9]

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[6] Id at p. 20.

[7] Id at p. 18.

[8] Id at p. 141.

[9] Id at p. 144.

Lung Cancer: The mortality rate is appreciably higher for Black males than non-minority males from age 50 to 70. A mortality crossover occurs during the 70's, which becomes more pronounced at age 85.[10]

Multiple Myeloma: Black males have a significantly higher mortality rate, which generally becomes more pronounced from age 50 to age 80. The gap narrows some at age 85, but the mortality rate for Black males is appreciably higher than for non-minority males.[11]

Prostatic Cancer: The mortality rate is generally significantly higher for older Black males than elderly non-minority elderly males at all ages. It becomes substantially greater with advancing age, especially in the 70's and particularly at age 80.[12]

Black and Non-Minority Females Aged 50 and Above

Cervix Uteri: The mortality rate for Black females 50 and above is substantially greater at all age levels than for non-minority females. This mortality gap widens with advancing age until it is almost three times as great for Black females at age 85.[13]

Colon and Rectal Cancer: Black females have a higher mortality rate after age 50, but a mortality crossover occurs at about age 80.[14]

Corpus Uteri Cancer: The higher mortality rate from this form of cancer persists for Black females after age 50. The gap widens with age and becomes more pronounced from age 70 to 80. Then, it narrows until the mortality rate becomes essentially equal at age 85 and above for Black and non-minority females, although elderly Black females still have a slightly higher mortality rate.[15]

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[10] Id at p. 146.

[11] Id at p. 148.

[12] Id at p. 150.

[13] Id at p. 140.

[14] Id at p. 142.

[15] Id at p. 143.

Esophageal Cancer: Older Black females generally have a much higher mortality rate from esophageal cancer than non-minority females from age 50 to 80. However, a mortality crossover does occur during the 80's. [16]

Lung Cancer: A consistently higher mortality rate exists for Black females from age 50 until the early 60's, when a mortality crossover occurs.[17]

Multiple Myeloma: The mortality rate is higher for Black females after age 50 and generally becomes more pronounced with advancing age. At age 70, Black females have a mortality rate from this form of cancer which is about twice as great as for non-minority females.[18]

III. Affordability

Inadequate income in retirement is, and continues to be, the number one problem affecting elderly Blacks. No other problem looms as large as the retirement income crisis which already affects many aged Blacks and threatens to engulf others. Inadequate income is a root cause for virtually every major problem impacting elderly Blacks, and is closely connected to their generally poorer health status when compared with older Whites.

Income clearly affects the ability of older Blacks to obtain necessary health care. It influences the timing and quality of health care that they receive. It affects their selection of food and frequently determines whether elderly Blacks have a well balanced and nutritious diet.

Aged Blacks are among the most economically deprived groups in our society by whatever barometer one chooses to use. In 1988, one out of every three Blacks 65 years of age or older was poor. The poverty rate for aged Blacks is more than three times as great as for elderly Whites: 32.2 percent vs. 10.0 percent in 1988. Overall, 785,000 Blacks 65 or older were poor. Individuals 65 or older were considered poor in 1988, under the U.S. Census Bureau definition, if their annual money income did not exceed $5,674 ($7,158 for an aged couple). This translates to $109 a week (about $138 a week for an elderly couple) to pay for housing, food, health care, transportation, clothing, and other day-to-day living expenses.

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[16] Id at p. 145.

[17] Id at p. 147.

[18] Id at p. 149.

**Poverty Status in 1988 Among Persons 65 or Older**
**(Figures in Thousands)**

| | Total | White | Black |
|---|---|---|---|
| Number of persons | 29,022 | 26,001 | 2,436 |
| Number of poor persons | 3,482 | 2,595 | 785 |
| Percent poor | 12.0% | 10.0% | 32.2% |

**Source:**
"Money Income and Poverty Status in the United States: 1988", Current Population Reports, Consumer Income, Series P-60, No. 166, Oct. 1989, p. 66.

In addition, hundreds of thousands of elderly Blacks have incomes teetering on the edge of poverty. Figures on near poverty (income within 25 percent of the poverty line) are not available for 1988. In 1987, 808,000 Blacks 65 or older were poor. Another 286,000 had incomes within 25 percent of the bare bones poverty threshold. The net impact is that 45.9 percent of all aged Blacks either lived in poverty or so close to the bare bones threshold that they could barely appreciate the difference.[19]

Rapidly rising health care costs have intensified problems for aged Blacks. Health care expenditures have increased well above the inflation rate for several years now.

This development has placed aged Blacks in a predicament. Critical daily needs have forced elderly Blacks to compromise their health care. Do they buy food or prescription drugs? Do they pay the rent or have a doctor check out a nagging ailment which has already lingered too long?

Many now postpone necessary health care until their illnesses become serious or reach a crisis state, simply because they do not have sufficient income to meet their basic needs. Unfortunately the threat of a costly, catastrophic illness is all too real for aged Blacks. The repeal of the Medicare benefits in the Medicare Catastrophic Coverage Act (Public Law 100-360) will be a major setback for older Blacks.

Sidney Rosen provided hard hitting and eloquent testimony about the high cost of health care and its impact on accessibility for older Blacks at a 1986 House Committee on Aging hearing on "Health Care Problems of the Black Aged". He said:

> Modern medicine in America is a wonderment and has the promise of providing quality health care, yet it does not and will not be accessible to all who need it because it is no longer a human service, but a business tied to our market economy.

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[19] "Money Income and Poverty Status in the United States: 1987", Current Population Reports, Consumer Income, Series P-60, No. 161, Aug. 1988, pp. 32 - 34.

> In the market place of services, it is the ability of the individual to pay for the service rather than the need of the individual.
>
> It is money rather than illness that creates and maintains the health care establishments. For most older people, aging produces increased medical problems, and these medical problems occur at a point in life where the income is fixed.
>
> The choice is often between medical care and/or food and utilities. Unfortunately, older people have been cruelly portrayed as having received a greater portion of the human services Federal dollars than they have a right to.[30]

The high cost of health care has also whittled away valuable protection provided by Medicare. Deductible, premium, and other related charges have all risen rapidly since Medicare began -- substantially above the inflation rate. The upward spiral has continued during the 1980's.

The Part A Hospital Insurance deductibles in 1989 ($560) is 14 times greater than when Medicare began in 1966 ($40). Since 1980, the Part A deductible has jumped by more than threefold, form $180 in 1980 to $560 in 1989.

The Part B Supplementary Medical Insurance premium has leaped forward more than tenfold during Medicare's existence, from $3.00 per month in 1966 to $31.90 ($27.90 basic premium plus $4 for catastrophic health insurance) per month in 1989. The bulk of this increase has occurred during this decade, when the Part B monthly premium has soared from $8.70 in January 1980 to $31.90 in 1989.

The Part B deductible for physician, hospital outpatient, and other covered services has risen by 25 percent, from $60 in 1981 to $75 currently.

Out-of-pocket payments for health care represent 15-percent of the elderly's income. This is basically the same proportion that existed prior to the enactment of Medicare and Medicaid.

The Villers Foundation (now Families U.S.A. Foundation) gave this assessment in its report on "The Other Side of Easy Street: Myths and Facts About the Economics of Old Age":

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[30] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, pp. 12-13.

> The sad fact is that, because of skyrocketing health care costs and the absence of truly comprehensive insurance coverage, the elderly today spend the same proportion of their incomes on health care as was the case before Medicare and Medicaid were established, two decades ago. In 1984, average out-of-pocket health care costs for the elderly accounted for 15 percent of their income, the same level that existed before Medicare was enacted.[21]

## IV. Accessibility

Accessibility to health care is still a major problem for older Blacks, despite enactment of Medicare and Medicaid. Both Medicare and Medicaid provide valuable protection for elderly Blacks and other older Americans, but these programs do not provide full reimbursement for all their health care needs. Thus, many aged persons purchase medigap policies to supplement Medicare coverage primarily, and, to a substantially lesser degree, Medicaid protection for low-income individuals.

The Secretary's Task Force on Black and Minority Health noted that the White aged population supplemented Medicare with private insurance more than twice the rate for the Black elderly population: 69 vs. 31 percent.[22] Updated information shows improvement in the elderly Black supplementary medical insurance rate. However, aged Whites continue to have medigap health insurance policies at more than twice the level for older Blacks. A National Center for Health Statistics survey reported that 79.0 percent of Whites 65 or older had private health insurance in 1986, compared to just 38.5 percent for aged Blacks.[23]

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[21] "On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age", a report of the Villers Foundation, January. 1986, p. 26.

[22] "Report of the Secretary's Task Force on Black and Minority Health, Volume I: Executive Summary", U.S. Dept. of Health and Human Services, Jan. 1986, p. 190.

[23] "Advance Data From Vital and Health Statistics of the National Center for Health Statistics", U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics, No. 139, Sept. 18, 1987, p.2.

The Secretary's Task Force further noted that more Whites than non-Whites (primarily Blacks) were reimbursed for physician and other medical services under Medicare in 1978. Moreover, the reimbursement rates were higher for elderly Whites than aged non-Whites (largely Blacks).

> ...Although data are sparse, an analysis of Medicare utilization information in 1978 revealed that more Whites than non-Whites were reimbursed for physician and other medical services (597 per 1,000 of enrolled Whites versus 521 per 1,000 enrolled non-Whites). Reimbursement amounts per person served that year also appear to be more for Whites ($373) than for non-Whites ($348).[34]

These figures further magnify the discrepancies in accessibility when perceptions of health are analyzed. In 1988, for example, nearly one out of every two (48.2 percent) elderly Blacks considered their health to be poor or just fair. Only about one of every four Whites aged 65 or older had this negative perception of their health. (See page 1 of this report for more detailed information.)

Another measure of accessibility concerns prescription medicines. Despite their much poorer health and greater need, older Blacks receive prescriptions, on the average, at about the same rate as elderly Whites. Moreover, the amount expended for prescriptions, on the average, is 10.9 percent less for aged Blacks than elderly Whites: $238 vs. $267 in 1987.

**Number of Prescriptions (In Millions) for Medicare Beneficiaries 65 Years of Age or Older in 1987**

| | Number | Average Per Person |
|---|---|---|
| Total | 487 | 15.3 |
| White | 421 | 15.4 |
| Black | 45 | 15.5 |

**Source:**
"National Medical Expenditure Survey Prescribed Medicines: A Summary of Use and Expenditures by Medicare Beneficiaries", Research Findings 3, NCHSR, Dept. of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, PHS 89-3448, Sept. 1989, p. 10

**Prescription Expenditures (In Millions) for Medicare Beneficiaries 65 Years of Age or Older in 1987**

| | Amount | Average Per Person |
|---|---|---|
| Total | $8,318 | $262 |
| White | 7,291 | 267 |
| Black | 694 | 238 |

**Source:**
"National Medical Expenditure Survey Prescribed Medicines: A Summary of Use and Expenditures by Medicare Beneficiaries", Research Findings 3, NCHSR, Dept. of Health and Human Services, Public Health Service, National Center for Health Services Research, and Health Care Technology Assessment, PHS 89-3448, Sept. 1989, p. 12.

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[34] "Report of the Secretary's Task force on Black and Minority Health, Volume I: Executive Summary", U.S. Dept. of Health and Human Services, Jan. 1986, pp. 190-1.

In 1988, aged Blacks and elderly Whites had essentially the same number of physician contacts: 9.0 vs. 8.7 per year. However, older Blacks have a higher morbidity rate than elderly Whites. They are much more likely to be confined to a bed with acute and chronic conditions than older Whites. Moreover, they have a higher rate of being bedridden during a year than elderly Whites.

**Number of Physician Contacts Per Year Per Person 65 Years of Age or Older in 1988**

| Race | Total | Telephone | Office | Hospital | Other |
|---|---|---|---|---|---|
| White | 8.7 | 0.9 | 5.4 | 1.0 | 1.3 |
| Black | 9.0 | 0.4 | 5.2 | 1.3 | 2.0 |

**Note:** Figures may not add because of rounding.

**Source:**
"Current Estimates From the National Health Interview Survey, 1988", U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics, Series 10, No. 173, Oct. 1989, p. 116.

Both aged Blacks and elderly Whites who have had a contact with a physician previously have similar interval patterns before seeing a physician. For example, 85.9 percent of Blacks 65 or older have less than a one-year interval for a physician contact. This is virtually identical for the White aged rate (85.8 percent).

These figures, on the surface, may seem to suggest that older Blacks are basically able to obtain the care they need. The statistics, though, do not provide in-depth information concerning the quality of care that elderly Blacks received. Nor do the figures indicate whether the care was satisfactory for the condition which necessitated the physician contact.

Many authorities agree that if Blacks had equal access to care as Whites, Blacks would have a significantly higher rate of health care usage because of their generally poorer health. This point of view was expressed in a recent article in JAMA.

> ...Blacks, on the average, are in poorer health than whites, which may be a consequence of life-course deficit in access to medical care as well as a generally lower level of living, as reflected by differences in average incomes and other indicators of socioeconomic status. Consequently, if there were real parity in access to medical care between the two racial groups, there would be a substantially higher use of health services on the average among black Americans."

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" "Access to Medical Care for Black and White Americans", by Robert J. Blendon, ScD; Linda H. Aiken, PhD; Howard E. Freeman, PhD; and Christopher R. Corey, MA, JAMA, Vol. Volume 261, No. 2, p. 278.

In 1988, the proportion of aged Blacks who were not hospitalized during the year was slightly lower than for elderly Whites: 82.1 percent vs. 83.3 percent. This pattern existed, although aged Blacks are much more likely to require institutionalization because their health status is poorer than for elderly Whites.

**Percent Distribution of Living Persons 65 Years or Older With Hospital Episodes During 1988**

| Race | None | One | Two | Three Or More |
|---|---|---|---|---|
| White | 83.3% | 12.3% | 3.1% | 1.3% |
| Black | 82.1 | 13.3 | 3.3 | 1.3 |

**Source:**
"Current Estimates From the National Health Interview Survey, 1988", U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics, Series 10, No. 173, Oct. 1989, p. 120.

Another useful barometer to analyze accessibility to health care for aged Blacks and older Whites is to compare the proportion who have a usual source of care and those who do not. In 1987, about 88.0 percent of all Blacks 65 or older had a usual source of care, compared to 91.5 percent for elderly Whites. The 1987 National Medical Expenditure Survey further found that 12 percent of aged Blacks did not have a usual source of care, in contrast to 8.5 percent for older Whites.

**Percentage of Persons 65 Years or Older With or Without A Usual Source of Care in 1987**

| | White | Black |
|---|---|---|
| With a usual source of care | 91.5 | 88.0% |
| Without a usual source of care | 8.5 | 12.0 |

**Source:**
Unpublished data from the 1987 National Medical Expenditure Survey: Household Component, U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment.

Elma Henderson, President of the Detroit City Council, perhaps summed up best the accessibility problems encountered by older Blacks when she testified in 1986 at a House Select Committee on Aging hearing on "Health Care Problems of the Black Elderly."

> Overall the Black elderly suffer more illness and die earlier. Compared to Whites, Blacks spend less on health. Elderly Blacks see a doctor less often, receive less preventive care, and are more dependent on self-diagnosis and self-treatment.
>
> They are more likely to have heart disease, strokes, diabetes, high blood pressure, and hypertension. The Black elderly more likely feel sustained unhappiness which makes them susceptible to mental breakdowns.
>
> In the middle age and a little beyond, the death rate for Blacks is twice that for Whites. At birth, Whites are expected to live about 5 years longer than Blacks.[3]

[3] Testimony at U.S. House Select Committee on Aging Hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 5.

V. Long-Term Care

Preliminary data from the 1985 National Nursing Home Survey revealed that nearly 1.5 million persons lived in 19,100 nursing homes, including more than 1.3 million individuals 65 years of age or older. These nursing home residents tended to be very old, White, and females.

More than 45 percent were 85 years of age or older. The average age was 84 years for elderly females, 81 years for aged males, 83 years for elderly White residents, and 81 years for elderly Black residents, according to preliminary data from the 1985 National Nursing Home Survey.

The likelihood of a person being placed in a nursing home increases dramatically with age. Nearly 22 percent of all persons 85 or older are in nursing homes, compared to slightly more than 1 percent for individuals 65 to 74 years old.

Overall, 93 percent of elderly residents were White, 6 percent were Black, and 1 percent were other races (Asians, Pacific Islanders, Native Americans, and Alaskan Natives). Aged White persons are more likely to live in nursing homes than elderly Blacks or those of other races. In 1985, 4.8 percent of Whites aged 65 and older were nursing home residents, compared to 3.5 percent of older Blacks and 2.0 percent of older people of other races. Almost 75 percent of all aged nursing home residents in 1985 were women.

The lower nursing home utilization rate for Blacks in comparison with Whites does not connote less need. Quite to the contrary. Aged Black suffer from higher levels of functional impairment than older Whites. The National Center for Health Statistics (NCHS) reported in its summary of the National Nursing Home Survey:

> ...Overall, 29 percent of the noninstitutionalized elderly who were of black or other races were functionally impaired in the activities of daily living or home management activities for at least 3 months, compared with only 19 percent of white people. Thus, elderly persons who were of black or other races were overrepresented among the noninstitutionalized most at risk of needing nursing home care. This finding suggests 'the use of a more extended support system among black persons than among white persons.' Other studies have shown that elderly black persons are more likely than elderly white persons to receive care at home."

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[27] "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey", by Esther Hing, U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, Division of Health Care Statistics, May 14, 1987, p.3.

NCHS noted that the lower rates of institutionalization for Blacks may be attributed to the substitution of informal mechanisms of giving care at home. Other factors also account for elderly Blacks' lower participation rate. As a practical matter, many older Blacks simply cannot afford the high cost of nursing care. Moreover, nursing homes are often viewed with suspicion by older Blacks because there is a popular perception that nursing homes are places where people go to die. Elderly Blacks have also been victims of discrimination by nursing home officials, even though it is prohibited.

**Nursing Home Residents 65 Years of Age and Older By Age, Sex, and Race in the United States in 1985**

| Age, Sex and Race | Residents | Percent | Number of Residents 65 Years and Older Per 1,000 Population 65 Years and Older |
|---|---|---|---|
| Total | 1,318,000 | 100% | 46.2 |
| **Age** | | | |
| 65-74 years | 212,100 | 16.1 | 12.5 |
| 75-84 years | 509,000 | 38.6 | 57.7 |
| 85 years or older | 597,300 | 45.3 | 220.3 |
| **Sex** | | | |
| Male | 334,400 | 25.4 | 29.0 |
| Female | 983,900 | 74.6 | 57.9 |
| **Race** | | | |
| White | 1,227,400 | 93.1 | 42.7 |
| Black | 82,000 | 6.2 | 35.0 |
| Other | 8,900 | 0.7 | 20.1 |

**Note:** Figures may not add because of rounding.

**Source:**
The National Nursing Home Survey: 1985 Summary for the United States, Hing, E., Sekscenski, E., Strahan, G., "Vital Health Statistics", Series 13, No. 97, U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, Jan. 1989, pp. 23-4.

Older Blacks are oftentimes denied entry to a nursing home because of the high cost of the care. NCHS reported from its 1985 survey that the average daily cost of skilled nursing care was $61 per day. This translates to $1,830 per month (for a 30-day month) and approximately $22,000 on an annualized basis. The average cost of intermediate care was $48 per day ($1,440 for a 30-day month and more than $17,000 for a full year).

These figures, it should be stressed are four years old. In 1989, skilled nursing care probably costs conservatively, on the average, from about $27,000 to $30,000 per year. In certain areas of the country nursing home costs can easily range from $40,000 to $50,000 per year.

## VI . Conclusion

In conclusion, older Blacks have poorer health than aged Whites by virtually any standard of measurement. Perhaps the most readily apparent is the significantly shorter life expectancy for Blacks than Whites. A mortality crossover does occur at more advanced ages. However, the differences in life expectancy between Blacks and Whites during the early, middle, and much of the later years of life provide compelling evidence that a major health gap exists in our nation.

In many respects, older Blacks have been relegated to a position at the back of the health care bus. Health care providers have often practiced "welfare medicine" on low-income aged Blacks.

Aged Blacks have been shortchanged, to a large degree, by our health care system. It is reflected in so many ways:

- Elderly Blacks have a much more negative perception about their health than aged Whites. Older Blacks are nearly twice as likely to view their health as poor or just fair than elderly Whites: 48.2 percent vs. 27.7 percent in 1988.
- The average number of bed days because of acute or chronic conditions is 55.1 percent greater among older Blacks than aged Whites: 21.4 days vs. 13.8 days.
- Aged Blacks have a higher morbidity rate and mortality rate from several illnesses than older Whites.

This report has attempted to assess the health status of elderly Blacks in four key areas: (1) epidemiology and mortality, (2) affordability, (3) access, and (4) long-term care. However,

limited and outdated data have presented formidable obstacles for the undertaking of this mission. Moreover, the analysis has been further hampered by outdated statistics and a general paucity of information. The harsh reality is that a comparatively small amount of statistical and other data are available to examine the health status of older Blacks. When information is available, it oftentimes applies to Blacks in general. The net impact is that any analysis at this stage must, at best, be a superficial attempt to assess the health care crisis which already affects so many older Blacks.

It is therefore recommended that governmental agencies -- such as the National Center for Health Statistics, the Health Care Financing Administration, the Census Bureau, and others -- make a concerted effort to gather more detailed and current information relating to health and the Black elderly. Appropriate federal agencies should confer with health professionals, the National Caucus and Center on Black Aged, researchers, and others to implement this recommendation in the most efficient and appropriate manner.

NCBA further urges a governmental agency to undertake a comprehensive and thorough study, either directly or by grant or contract, to build upon this initial analysis of the health status of aged Blacks.

Item 3

**STATEMENT BY**

**NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.**

**ON**

# ELIMINATING DISCRIMINATORY PRACTICES IN NURSING HOMES

**SEPTEMBER 1990**

The National Caucus and Center on Black Aged (NCBA) has a long-standing interest in eliminating all forms of discrimination against elderly Blacks. NCBA has in recent years focused greater attention on discriminatory practices in nursing homes and other long-term care facilities. This has become a major concern for NCBA. Discrimination against Blacks in nursing homes is often expressed in economic terms, but it has racial implications.

## A. Background and Statistical Information

The 1985 National Nursing Home Survey reported that 93 percent of all elderly nursing home residents were White, 6 percent were Black, and 1 percent were other races (Asians, Pacific Islanders, Native Americans, and Alaskan Natives). Aged Whites were more likely to reside in nursing homes than elderly Blacks or other minorities. In 1985, 4.8 percent of all Whites 65 or older were nursing home residents, compared to 3.5 percent among the aged Black population, and 2.0 percent among all other elderly minority groups.

The lower nursing home utilization rate for older Blacks does not connote less need. Quite to the contrary, aged Blacks and other elderly minorities suffer from higher levels of functional impairment than older Whites. The National Center for Health Statistics reported in its summary of the National Nursing Home Survey:

> "...Overall, 29 percent of the non-institutionalized elderly who were of Black or other races were functionally impaired in the activities of daily living or home management activities for at least 3 months, compared with only 19 percent of white people."[1]

NCHS noted that the lower rates of institutionalization for Blacks may be attributed to the substitution of informal mechanisms of providing care at home, quite often by a family member. Other factors also account for elderly Blacks' lower participation rate. As a practical matter, many older Blacks

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[1] "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey", by Esther Hing, U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics, Division of Health Care Statistics, May 14, 1987, p. 3.

simply cannot afford the high cost of nursing care. Elderly Blacks have also been victims of discrimination -- whether overt or covert -- by nursing home officials.

The 1989 final report of the Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County [Tennessee] found widespread discriminatory practices in nursing homes against aged Blacks. The report pointed out that 75 percent of all persons eligible for Medicaid in Memphis, Tennessee in 1978 were Black individuals. However, Blacks accounted for less than 8 percent of all Medicaid recipients in nursing homes in Memphis. The Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County gave this blunt assessment:

> "...Truthfully, that shockingly low percentage was the direct effect of institutional racial segregation. At the time prior to the lawsuit, Hickman vs Fowinkle, there were some nursing homes that were intentionally and knowingly denying access to Black patients. Of more significance, other nursing homes were denying access to Black patients through their policies and practices and various criteria employed in the admissions process. Although these nursing homes were not intentionally discriminating, they were indirectly denying access to Blacks."[2]

A 1988 survey by the Tennessee Office of Civil Rights found that only 3.8 percent of all Blacks 65 or older living in Shelby County were in nursing homes, compared to 5.1 among elderly Whites. Thus, aged Whites were 34.2 percent more likely to be in nursing homes than elderly Blacks, although older Blacks normally have greater functional impairments and more chronic conditions than aged whites.

The Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County concluded: "The racial distribution of nursing home care evolved primarily because of racial and economic discrimination."[3]

Quite often, nursing homes will only admit private paying patients, who typically are White because they have the financial resources to pay for nursing home care. These individuals are allowed

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[2] "Open the Door To Better Health Care", Final Report of the Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County, prepared by Office for Civil Rights

to remain in the nursing home after they exhaust their resources if Medicaid will pay for their care. This type of admission practice has a disparate discriminatory effect for aged Blacks who frequently cannot gain admission to a nursing home on their own because the cost of the care exceeds their income. Thus, they may never have an opportunity to be a Medicaid resident in a facility with this type of an admissions practice because they can never gain entry in the very beginning.

B. Court Cases and Remedies

Two fairly recent court cases in Tennessee provide a mechanism to protect elderly Blacks from discriminatory practices by nursing home administrators and personnel. Both cases relied upon Title VI of the 1964 Civil Rights Act, which prohibits discrimination against any recipient or applicant for federally funded benefits because of race, color or national origin.

1. Hickman vs. Fowinkle

Public interest lawyers in the Hickman vs. Fowinkle case sued on behalf of aged Black residents in Shelby County, Tennessee, claiming (1) older Blacks were denied access to nursing homes, and (2) elderly Blacks were directed to residential homes which did not provide professional medical care or qualify for Medicaid reimbursement. Aged Whites, on the other hand, were directed toward conventional nursing homes.

The Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County gave this assessment in its report:

> "For many years in Shelby County there existed a system of long-term health care in which practically all Blacks were admitted to one nursing home. And that public facility, known as the Shelby County Hospital, was commonly referred to as the 'poor-house.' There were also several all-White nursing home facilities and as recent as 1978 and 1979, that dual system of health care was still in existence and virtually impenetrable by the Black community."[4]

A negotiated settlement was reached in the Hickman vs. Fowinkle class-action lawsuit after six years of litigation. The U.S. District Court for the Western District of Tennessee ordered the Tennessee Dept. of Health and Environment and the Department of Human Services not to discriminate against any applicant or recipient of Tennessee's Medicaid program.

Tennessee has increased its efforts to ensure civil rights compliance in all nursing homes accepting federal funds. Another development from the case was the establishment of the Office of Civil Rights Compliance within the Tennessee Dept. of Health and Environment.

Nursing homes with a Black resident population 10 percentage points or more below the proportion that Blacks represent in Shelby County are considered to be in noncompliance. The Committee on Long-Term Health Care Placement for the Elderly Minority in Shelby County reported that aged Blacks represented 35.5 percent of all persons 65 or older in Shelby County. Moreover, the Committee noted that 50 percent of the Shelby County nursing homes certified for Medicaid were in noncompliance.[5]

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[4] Id at p. 3.

[5] Id at p. 6.

2. Linton vs. Commissioner

Another recent significant case based on Title VI of the 1964 Civil Rights Act is Linton and Carney vs. Commissioner of Health and Environment. The U.S. District Court for the Middle District of Tennessee found that discrimination by health care providers against Medicaid patients has a disparate adverse impact on minorities. The Court further found that policies limiting access to care for Medicaid patients disproportionately affect Blacks because Blacks are more heavily dependent upon Medicaid since they have a much higher incidence of poverty than Whites. Thus, the policies were found to violate regulations under Title VI of the 1964 Civil Rights Act.

The issue in this case involved a Tennessee Medicaid policy, permitting Medicaid participating nursing homes to limit the number of beds in their facilities that would be certified for Medicaid patients. This, in effect, was a private quota system enforced by the state.

The state defended the policy, claiming that federal statutes and regulations authorize certification of "distinct parts" of health care facilities. The Court rejected this argument, noting that the "federal distinct part" certification is intended to accommodate the delivery of qualitatively different types of care, such as inpatient hospital care in one wing and skilled nursing facility care in another wing.

The Court also found that Tennessee's policy caused widespread displacement of nursing home residents who exhausted their resources and then attempted to qualify under Medicaid in the facility. In addition, the policy impaired access for low-income Medicaid recipients who sought admission in health care facilities.

The clear message in this case is that discrimination manifested in economic terms may have racial and cultural connotations which have a disparate impact on minorities. If this occurs, the court will find a violation against Title VI of the 1964 Civil Rights Act.

C. Conclusion

In conclusion, NCBA is deeply concerned about nursing home practices and policies that have a disparate discriminatory impact for aged Blacks. NCBA is firmly committed to eliminating both disparate and overt discriminatory practices which affect elderly Blacks at nursing homes and other long-term care facilities. NCBA sincerely hopes to have the support and involvement of the Senate Committee on Aging and the Congressional Black Caucus to make these objectives a reality.

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